



Wardenburg Health Center

University of Colorado at Boulder
119 UCB, Boulder, CO 80309-0119

Authorization for Treatment of a Minor

I, _____, being the parent or legal guardian of

Name *Social Security Number*

give my consent for emergency and routine medical and/or surgical treatment of this minor at Wardenburg Health Center (WHC) should his/her condition so require it per the judgment of a WHC health provider. As long as the medical and/or surgical treatment considered necessary in the situation is in accordance with generally accepted standards of medical practice for the particular type of injury or illness involved, I impose no specific limitations or prohibitions regarding treatment other than those that follow:

If there are medical/physical limitations/prohibitions, specify here: _____

I understand that this authorization is good until the minor mentioned above reaches his/her 18th birthday.

Signature (Parent or Guardian) *Date*

Street Address

City *State* *Zip Code*

Home Telephone: _____ Work Telephone: _____

If this is a verbal / phone authorization:

Signature of WHC staff receiving authorization *Signature of Witness to the verbal/phone authorization*