Missouri Western State University
4525 Downs Drive, St. Joseph MO 64507
www.missouriwestern.edu

Esry Student Health Center – Blum 203
Phone (816) 271-4495
Fax (816) 271-4498
E-Mail: health@missouriwestern.edu

CONSENT TO TREAT A MINOR FORM

Being the parent or legal guardian of _____ (minor's printed name), I _____ (parent/guardian's printed name) do consent to any medical diagnosis, treatment or referral that may be deemed necessary for my minor child. Further, I understand that all efforts will be made to contact me prior to any emergent treatment. In the event I cannot be reached in an emergency, I give permission to the Missouri Western State University / Esry Student Health Center to make the decisions necessary for treatment. I further understand that providers attending to my child will take all reasonable safety precautions during their care.

Further, as parent or legal guardian, I am responsible for the health care decisions of my minor child and agree that their insurance plan is the primary plan to pay for the care or treatment that is given to my child. As the parent or legal guardian, I am responsible for any outstanding balance that the insurance company does not incur.

Minor's Name: _____

Minor's Date of Birth: _____

Parent/Guardian Signature: _____ Date: _____