Missouri Western State University
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Esry Student Health Center – Blum 203
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MWSU Esry Student Health Center

General Consent to Treat a Minor and Disclosure of Records

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 and/or 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.

I give permission for my minor child to receive necessary medical, mental health or emergency treatment at Ersy Student Health Center or an authorized hospital/medical facility while an enrolled student at Missouri Western State University. I understand that any medical case has risks and benefits, but these cannot be fully described here in anticipation of any potential treatments or procedures.

I further understand that, once my child reaches the age of maturity, my consent for treatment is no longer required.

Minor's Name: _____ G#_____

Minor's Date of Birth: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

Emergency Phone Numbers

( )_____ Home ( )_____ Work

( )_____ Cell ( )_____ Other

List an additional Emergency Contact (optional):

_____ Name (printed) _____ Telephone Number