University of Nevada, Reno
Student Health Center
Mail Stop 196
Reno, NV 89557
(775) 784-6598
(775) 784-1298 fax

CONSENT FOR TREATMENT OF A MINOR

Information and Consent

Name of Minor: _____ Date of Birth: _____

Address (Street, City, State, Zip Code): _____

Parent/Guardian Phone Number (Home and Work): _____

I, the undersigned, as the parent or legal guardian of _____ (a minor), hereby authorize such diagnostic, medical and/or surgical treatment of such minor as may be considered necessary or appropriate under the circumstances for the treatment of any illness or injury of the minor. The attending physician, appropriate staff, and The University of Nevada at Reno and it's officers, regents, and employees shall not be responsible in any way for any consequences from said diagnostic, medical and/or surgical treatment and are hereby released from any and all claims and causes of action that may arise, grow out of, or be incident to such diagnosis, treatment, or surgery insofar as the law allows and provided that these services are performed with ordinary care and to the best of their ability.

_____

SIGNATURE OF PARENT/LEGAL GUARDIAN DATE

_____

PRINT NAME

Medical Information Related to Minor:

Allergies: _____

Current Medications: _____

Date of Last Tetanus Booster: _____

Pertinent Medical History: _____

_____

_____