

## Authorization for Treatment of a Minor

I am the parent or legal guardian of \_\_\_\_\_, currently a minor, whose date of birth is \_\_\_\_/\_\_\_\_/\_\_\_\_.

I authorize Colorado State University Hartshorn Health Service to provide medical and/or mental health care to my son/daughter, including but not limited to, diagnostic examinations (including radiological and laboratory testing), tuberculosis screening, verification and/or administration of immunizations, and necessary medical treatment including minor surgical procedures, and mental health counseling.

I understand that should my minor child need more invasive diagnostic or surgical procedures, attempts will be made to contact me before such care is initiated.

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name

\_\_\_\_\_  
Relationship