CONSENT FOR TREATMENT OF UNEMANCIPATED MINOR

Must be completed for application to be accepted.

I, ____________________________________________, being the parent or legal guardian of
_________________________________________________ give my consent for both emergency
and routine medical (to include mental health care) and surgical treatment of this minor, at
Colorado State University Health & Medical Center, UCHealth Poudre Valley Hospital, or by a
private physician, emergency medical technician or dentist. It is understood that this
authorization is given in advance of any specific diagnosis or treatment as long as it is considered
necessary in the situation and is in accordance with generally accepted standards or 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 none, so state):

__________________________________________________________________________________________

This authorization shall remain in effect until August 31, 2020.

Signature of parent or legal guardian ___________________________ Date ______________