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 UC Health 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, 2026.

_____ _____

Signature of parent or legal guardian Date