ST. MARY'S UNIVERSITY

Student Health Center

One Camino Santa Maria
San Antonio, TX 78228-8545

Medical Consent for the Treatment of a Minor

Date: ___/___/_____
Name of minor: _____
DOB of minor: ___/___/_____ Age: _____ Social Security #: _____-____-_____
Address: _____ City: _____ State: ____ Zip: _____

I, _____ grant permission to the *St. Mary's University Student Health Center* to treat my child in the event a medical situation should arise. I understand that the Student Health Center is staffed with appropriate medical personnel who will triage my child and communicate with me about any further disposition necessary to ensure the best possible health care for my child. I also grant permission to the Student Health Center to make emergency decisions that might require referral to a hospital or off-campus facility. I grant permission for hospitalization and treatment of my child if it is deemed necessary.

I understand that by law, the *St. Mary's University Student Health Center* cannot assume responsibility for payment of any fees or charges for medical services performed. I understand that I must accept responsibility for settling payment for any medical services rendered to my child during such a medical emergency.

Parent or Legal Guardian: _____ Relationship: _____
Phone number in case of emergency: Home: _____ Work: _____

Alternate emergency contact: _____ Relationship: _____
Phone number of alternate emergency contact: _____

Preferred Hospital in event of emergency: _____
Family Physician or Pediatrician: _____ Office Phone #: _____

_____ _____/_____/_____
Signature of Parent or Guardian **Date**

_____ _____/_____/_____
Signature of Student **Date**