

**CHADRON MEDICAL CLINIC, P.C.**  
**CHADRON STATE COLLEGE HEALTH SERVICES**

CONSENT TO TREAT MINOR CHILD (consent is required for all students under age 19)

Please Print all Information

I, \_\_\_\_\_ Parent or legal guardian of \_\_\_\_\_ (student)  
birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_ do hereby consent to any medical care and to the administration of anesthesia determined  
by a physician to be necessary for the welfare of my child while said child is a student enrolled at Chadron State College  
and I am not reasonably available by telephone to give consent.

This authorization is effective from \_\_\_\_ 08/1/2026 \_\_\_\_ to \_\_\_\_ 05/31/2027 \_\_\_\_.

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Witness Name (please print)

***This consent form should be provided to Chadron Medical Clinic, P.C. and will  
be kept in patient's medical record.***

Additional Information below will assist in treatment if it can be furnished with the consent but is not required.

Family Address \_\_\_\_\_

Telephone: Father \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_

Mother \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_

Child's Birthdate \_\_\_\_\_ Last Tetanus \_\_\_\_\_

Allergies to drugs of foods \_\_\_\_\_

\_\_\_\_\_  
Special Medications, Blood Type or Pertinent Information

\_\_\_\_\_  
Child's Physician \_\_\_\_\_ Phone \_\_\_\_\_

Insurance \_\_\_\_\_ Policy # \_\_\_\_\_

Preferred Hospital \_\_\_\_\_