AUTHORIZATION TO CONSENT MEDICAL TREATMENT OF MINORS

The undersign (parent/guardian) of _____ who is _____ years old, hereby authorizes the medical, counseling and athletic training staff of Central Wyoming College, as agents for the undersigned to consent to any diagnostic procedure (including x-ray), to administration of any counseling, medical, surgical treatment, or to any hospital care when any or all foregoing is deemed advisable by and is to be rendered under the general supervision of any physician and/or surgeon licensed under the provisions of the Medical Practice Act or of a Dentist licensed under the provisions of the Dental Practice Act. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

The undersigned also consents to the release of medical information to other institutions accepting the patient for medical care relative to continuity of the care for this visit. A photo static copy of this authorization shall be considered as effective and valid as the original.

Print Name _____ Date ____/____/_____
(parent or guardian)

Signature _____
(parent or guardian)

This consent shall remain effective until_____20_____