

**Consent for Treatment of a Minor**

Minor’s Last name, First name, middle initial Date of Birth Buffalo Gold Card #

I, the parent or legal guardian of , hereby consent to outpatient care encompassing routing diagnostic procedures, inpatient and emergency care, and medical treatment for the minor as may be considered necessary. The attending physician(s), nurse practitioner(s), West Texas A&M University and its employees shall not be responsible in any way for any consequences from said diagnostic, medical, and/or surgical treatment and are hereby released from any and all claims and causes of action that may arise, grow out of, or be incident to such diagnosis, treatment, or surgery insofar as the law allows, and provided that these services are performed with ordinary care and to the best of their ability. I agree to assume financial responsibility for all expenses of such care.

Allergic to drugs

Special Medications or other pertinent medical information:

Signature of parent/legal guardian Printed name of parent /legal guardian

Time and Date

Parent or Legal Guardian’s contact # work phone number of parent/guardian

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