



CONSENT FOR MEDICAL TREATMENT OF A MINOR
(Consent for treatment of students under 18 years of age)

If a new/transfer student is under the age of 18, the following form is required in order to provide legal consent for any medical care should it be necessary. Please complete and return this form to **Lamar University Student Health Services, 857 E. Virginia, PO Box 10015, Beaumont, Texas, 77705 Office (409)-880-8466 Fax (409) 880-7703**

Name of Minor (Student): _____

Date of Birth: _____ ID# or SSN: _____

Address (Street, City, State, Zip Code): _____

Parent/Guardian Name: _____ Relation to minor: _____

Phone number: () _____ () _____ () _____
Home Cell Work

I, _____, the natural parent/legal guardian of _____
(parent/legal guardian) (minor/student)

give my consent for medical and/or surgical treatment of this minor by a licensed health care professional should the need arise while he/she is attending Lamar University or Lamar Institute of Technology. I am aware that the practice of medicine is not an exact science and that no guarantees can be made concerning the results of treatment. I grant permission for treatment provided according to generally accepted standards of medical practice. I understand that I am financially responsible for all charges whether or not my insurance pays the Student Health Center. I authorize the disclosure of my health care information to my insurance company and their agent for the purpose of obtaining payment for services and determining benefits for related services. This consent will be in effect from this date until minor is 18 years of age unless cancelled earlier by me in writing.

Signature of Parent/Legal Guardian Date: _____

*****FOR CLINIC USE ONLY*****

Parental/guardian giving verbal/phone consent for treatment was:

Name of Parent/Legal Guardian Time and Date

By _____ AND
Signature of Lamar Health Center staff obtaining consent

By _____
Signature of Lamar Health Center staff witness