Gable Health and Counseling Center
Consent for Medical Care and Emergency Treatment of a Minor

In presenting my son/daughter for diagnosis and treatment

Name: _____for_____

☐ Mother ☐ Father ☐ Legal Guardian (name of student)

of _____ years of age, hereby voluntarily consent to the rendering of such care, including diagnostic procedures, medical treatment and laboratory tests, by authorized members of the Gable Health Center staff or their designees, as may in their professional judgment be necessary.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my child's condition.

I have read this form and certify that I understand its contents.

I hereby give my consent to: The Gable Health and Counseling Center who will be caring for my child to arrange for routine or emergency medical care and treatment necessary to preserve the health of my child.

I acknowledge that I am responsible for all reasonable charges in connection with care and treatment rendered.

_____ _____

Mother, Father, or Legal Guardian signature Date

In case of emergency I can be reached at:

_____