Colby Health Services

AUTHORIZATION TO TREAT A MINOR

If student is under age 18, a parent or guardian must complete and sign this form. Without a parent's or guardian's signed authorization, Colby Health Services cannot provide care for your student.

Permission for release of medical information

I authorize release of relevant medical information to my insurance company for the purpose of reimbursement.

Parent/Guardian signature: ____Date: ________________

Printed name: ____

Permission to contact home provider

I authorize Colby Health Services to contact the provider whose name appears on the history and physical form about any information missing from medical examination or immunization record.

Parent/Guardian signature: ____ Date: _______________

Printed name: ____

Permission for medical care

I authorize Colby Health Services to provide medical services or when circumstances require immediate action to proceed according to standard medical practice in the treatment of ___________________________________

(Student Name)

Parent/Guardian signature: ____ Date: ________________

Printed name: ____