



Consent to Treat Minor

Date: _____

I, _____ consent to the treatment of my
minor child, _____, date of birth _____.

I agree to have my son/daughter be seen by the Director of Student Health
(R.N. Helen Rice) or by one of Guilford College's contracted Nurse
Practitioners.

I do/do not wish to be contacted for each visit to discuss the treatment plan.
By signing this form, I realize my child may not be able to pick up over the
counter medicine suggested or prescriptions written for their treatment. I
accept responsibility for obtaining all prescribed pharmaceuticals and any
medical treatment needed beyond the scope of treatment offered at the
Guilford College Student Health Center.

Insurance Coverage Provider

Policy Number _____

Name on Policy _____

Signature of Parent or Legal Guardian
(if participant is under 18 years of age)

Date

Phone numbers to be reached:

Home:

Work:

Cell: