COLORADO CHRISTIAN UNIVERSITY
Grace and Truth

Authorization to Treat Minors

I,_____ being the parent or legal guardian of_____ , give my consent for both emergency and routine medical treatment at CCU Health Services should his/her condition so require, per the judgment of the CCU Health Services care provider. As long as the treatment is considered necessary in the situation, and is in accordance with generally accepted standards of medical practice for the particular type of injury or illness involved. I impose no specific limitations or prohibitions regarding treat other than as follows: (If none, so state)

_____
_____
_____
_____
_____
_____
_____
_____
_____

I understand that the authorization is effective until the time in which the minor named above reaches his/her 18th birthday. Please note that this authorization is only required if the student will not be 18 years of age on the first day of classes.

Name of Student: _____ Student ID: _____

Signature of Parent or Guardian: _____ Date: _____

Cell Phone: _____ Work Phone: _____

Please return this form via mail, e-mail, or fax to:

CCU Health Services | 8787 West Alameda Avenue | Lakewood, CO 80226

healthservices@ccu.edu | P: 303.963.3365 | F: 303.301.8365 | M: 303.503.9091

Updated: 07/2018