I. 2.2

Consent Form for Medical Treatment of a Minor

I/We_____

(Print Full Name)

Of_____

(Address)

Do hereby state that I am (we are) the parent(s) or legally appointed guardians of

_____

(Print minors full name)

A minor born on _____. I/We hereby give my/our voluntary

(Birth date)

Consent to _____who will be caring for my/our

(Cleveland State University)

Child in my/our absence for the period of _____to _____

(Start Date) (End Date)

To authorize routine or emergency medical/dental care and treatment necessary to preserve the health of my/our child including diagnostic procedures, surgical and medical treatment by authorized healthcare providers and/or dentists licensed to practice medicine in any state.

_____

Date

_____

Signature of Parent or Legal Guardian

_____

Signature of Parent or Legal Guardian

_____

Signature of Witness