CONSENT TO MEDICAL, DENTAL, OR HOSPITAL CARE

Name (Last, First, Middle)	Date of Birth
Address (City, State Zip)	
Telephone	Cell
E-Mail	

I consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care under the general or special supervision and upon the advice of or to be rendered by a physician and surgeon licensed under the Medical Practice Act. This authority also extends to any x-ray examination, anesthetic, dental, or surgical diagnosis or treatment and hospital care by a dentist licensed under the Dental Practice Act. I further agree to pay all charges for the dental, medical, or hospital care or treatment.

As an adult over 18 years of age, I am responsible for my health care decisions and am authorized to consent to the services to be rendered. I represent that my consent to and agreement to pay for the dental, medical, or hospital care or treatment to be rendered is legally sufficient and that no consent from any other person is required by law.

Print Name	
Signature	Date

Please send this consent form to us **by mail or fax**; or your child may bring it with him/her to College Days.

Calvary University
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Fax: 816-331-4474
E-mail: admissions@calvary.edu