HARRIS - STOWE STATE UNIVERSITY

Office of Student Health Services

Consent to Treat

Students under the age of 18 years old

STUDENT NAME_____ DATE OF BIRTH_____

I,_____ give consent for _____,
PARENT/GUARDIAN STUDENT

To receive medical services from the health care professional assigned to Student Health Services, local hospitals and/or other licensed medical facilities for illness or injury.

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

Contact information:

(_____)_____ (_____)_____
HOME MOBILE

_____
E-MAIL