Consent to Treat

Providence Medical Center
Wayne State College Student Health

Please **print** all information.

I, ____
Student Name

whose birthdate is _________/________/_______, do herby consent to medical care as determined by a physician to be necessary for my welfare while a student enrolled at Wayne State College.

This authorization is effective from _______/______/______ to ______/______/______.

If the student is under 19 years of age, the parent or legal guardian must sign.

____ _____/_____/______
Student Signature (or Parent or Legal Guardian) Date

This consent will be provided to Providence Medical Center and will be kept in the student's medical record.

Additional information below will assist in treatment:

Student home address: ____

Student phone number: ____

Student last tetanus: ____/____/______ Allergies: ________________________________

Other permanent medical information: ____

____

Student physician: ______________________________ Physician phone: ____________________

Preferred Hospital: ____

Father's name: ______________________________ Phone: ____________________

Mother's name: ______________________________ Phone: ____________________

Insurance: ______________________________ Policy #: ____________________

Subscribers name: ______________________________ Date of birth: ____/_____/______

Subscriber's relationship to student: ____

WSC Student Health 10/2023