Wayne State College Consent to Treat Form

Providence Medical Center
WSC 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 _____ .
Start date End date

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

Student signature:_____ Date: _____

Parent or legal guardian signature:_____

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:_____

Allergies:_____

Other pertinent medical information:_____

_____

_____

Father's name: _____ Phone: _____

Mother's name:_____ Phone: _____

Please ensure the student has a copy of their insurance card while attending WSC.

WSC Student Health 06/2026

Accessibility notice: Wayne State College is committed to providing information that is accessible to all users. If you experience difficulty accessing the information in this document or require it in an alternative format, please contact WSC Student Health at 402-375-7470 or studenthealth@wsc.edu for assistance.