



## Treatment Authorization

I authorize the Hasting College Stone Health Center staff to:

- Administer medical first aid and services (including immunizations)
- Perform emergency care and/or to refer treatment to a local physician or medical facility if necessary
- Provide mental health counseling and/or refer to a local mental health care provider

---

Student Name (Print) DOB

---

Student Signature Date

**If you are under the age of 19, your parent or guardian must sign below.**

<hr/>	<hr/>
Parent Guardian Signature	Date
<hr/>	
Relationship to student	

**All students are strongly encouraged to have health insurance.**

**Please provide your health insurance information below.**


Please scan and return this form via email to [healthcenter@hastings.edu](mailto:healthcenter@hastings.edu).