Hastings College

Stone Health Center

TREATMENT AUTHORIZATION

I authorize the Hastings College Health Center to administer medical and first aid services (including immunizations); to perform emergency care and/or to refer treatment to a local physician or medical facility if deemed necessary.

_____

Print Student Name (first, middle initial, last) Date of Birth

_____

Signature Date

Are you under the age of 19 years? If so, your parent or guardian <u>MUST</u> sign below:

_____

Parent/Guardian Signature Date

_____

Relationship to Student

Healthcare Insurance is required of <u>ALL</u> students:

Name of Health Insurance Company_____

Policy Number_____

Group Number_____

PLEASE attach copy of insurance care (front and back). Student should also carry an insurance card.

Please check with your insurer about procedures to follow if off-campus medical; attention is needed, i.e. hospital or clinic care. Specific notes, are appreciated.

_____

_____

_____

Usual Healthcare Provider or Clinic:

Name_____

Address:_____

Street

_____

City State Zip

Phone Number: (_____)_____