



## Health and Wellness Services

This TREATMENT AUTHORIZATION  
must be signed by a parent or guardian if the student is under 18.

I hereby authorize and give consent to the Health and Wellness Services of Washington State University, or any licensed physician, to perform upon or administer to:

NAME OF STUDENT \_\_\_\_\_  
Last First Middle

any reasonably necessary medical or surgical treatment. I also give permission to administer whatever anesthetic may be necessary or advisable during medical or surgical procedures. This authorization is intended to cover emergency treatment, immunizations, injections, minor operations and procedures.

In the event of indicated major surgery, the Health and Wellness Services of WSU or physicians are not hereby excused from attempting to contact me by phone, or mail, before relying upon this authorization. This authorization does not entitle the service or physician to render any medical or surgical treatment without the student's personal consent, unless the student is unable to give consent.

This permission is good only while the student is attending Washington State University and only until the student has attained his or her eighteenth birthday.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone Number: \_\_\_\_\_

Relationship to Student: \_\_\_\_\_

*Mail directly to:*

HEALTH & WELLNESS SERVICES  
Washington State University  
PO Box 642302  
Pullman, WA 99164-2302