Cougar Health Services

WASHINGTON STATE UNIVERSITY

This TREATMENT AUTHORIZATION

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

I hereby authorize and give consent to Cougar Health 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, Cougar Health 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**:**

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