WESTERN WASHINGTON UNIVERSITY

Student Health Center

MINOR AUTHORIZATION FOR EMERGENCY MEDICAL CARE

TO: Western Washington University and any other health care provider

This is to certify that I/we _____

the _____ of the child named below, do authorize and direct any of the above
(Mother, Father or Guardian)
to render medical or surgical care including anesthesia, laboratory work, x-rays, and other procedures necessary in the Emergency Medical Care of the below named minor:

Name of Child	WWU ID Number	Date of Birth

During the period from: _____ to _____
Date Date

I/we understand that every effort will be made by the university staff to contact the parents or guardians of the child prior to the provision of services, but otherwise consent to the providing of such services without prior authorization.

Health Insurance Provider _____ Policy Number _____

Medical information:
Allergies, medications, last tetanus shot_____

_____
Name of Family Physician

_____
Address City, State, Zip Area Code-Phone Number

_____
Signature of Guardian

_____
Address City, State, Zip Area Code-Phone Number

Fax completed form to: WWU Student Health Center, 360.650.3883

Scan and e-mail completed form to: Student.Health@wwu.edu

Mail completed form to: WWU Student Health Center, 516 High Street, Bellingham, WA 98225-9132