



## HEALTH CENTER WHITWORTH UNIVERSITY

### TREATMENT AUTHORIZATION

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

Medical and surgical authorization:

I hereby authorize and give my consent to the healthcare providers of Whitworth University or their designated licensed provider to perform upon or administer to:

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(name of student)

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

In the event of indicated major surgery or major operation, university authorities or healthcare providers are not hereby excused from attempting to contact me by phone, or mail, before relying upon this authorization. This authorization does not entitle the healthcare providers 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 Whitworth University and only until the student's 18th birthday.

DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

RELATION TO STUDENT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_

Please mail this to: Whitworth University  
Health Center  
300 West Hawthorne Road  
Spokane, WA 99251