SOUTHERN ILLINOIS UNIVERSITY EDWARDSVILLE HEALTH SERVICE
0222 Student Success Center
Campus Box 1055
Edwardsville IL 62026-1055
Telephone 618-650-2842 Fax 618-650-5839

STUDENT NAME _____

ID# _____

Date of Birth _____

CONSENT OF TREATMENT

REQUESTED AUTHORIZATION IS REQUIRED from a parent, legal guardian, or nearest of kin, if an individual is less than 18 years of age.

I hereby give consent and authorize the Health Service at Southern Illinois University Edwardsville to provide medical care/treatment to whatever extent is deemed advisable within the best judgement of the medical staff to the above named individual.

Signature _____ Relationship _____

Date _____

Witness _____