



## Sindecuse Health Center

### Medical Treatment Authorization

For patients under the age of eighteen (18) to be seen at the Sindecuse Health Center, this form must be signed. Health Center staff make every effort to contact you in the event of an emergency or serious illness.

I hereby authorize Sindecuse Health Center staff of Western Michigan University to administer medical treatment to my son/daughter. This authorization is effective from the date of signature until the patient is of legal age or ineligible to use the facility's services.

\_\_\_\_\_  
Minor's Name Printed

\_\_\_\_\_  
WIN (WMU Identification Number)

\_\_\_\_\_  
Parent or Guardian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian's Name Printed

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Work Phone