WICHITA STATE UNIVERSITY STUDENT HEALTH SERVICES
CONSENT FOR TREATMENT OF A MINOR – MEDICAL RELEASE AND AUTHORIZATION
(to be completed by parent or legal guardian)

I, the undersigned, as parent or legal guardian of _____ ("Student") have the legal authority to give consent for the treatment of this minor. I hereby authorize Wichita State University Student Health Services ("SHS") to provide such diagnostic or medical treatment to my Student as may be considered necessary or appropriate under the circumstances. This may include, but is not limited to laboratory work, x-rays, EKG's, administration of medications, and emergency care as deemed necessary.

I grant permission for the transfer of my Student to a hospital or other health care facility if deemed necessary by the medical provider.

I understand that every effort will be made by SHS to contact me in a timely manner regarding my Student's condition. However, emergency medical treatment will not be withheld or delayed based on whether or not I have been contacted.

I understand that, as the parent or legal guardian of the Student, I am responsible for all financial charges related to any medical services provided by SHS.

This consent will be in effect from the date of my signature below until the Student is 18 years of age, unless cancelled earlier by me in writing.

Parent/Legal Guardian Name (please print) _____

Parent/Legal Guardian Signature _____

Date: _____

Name of Student: _____

Student Date of Birth (month/day/year): _____

WSU ID: _____

Please complete and return this form as soon as possible.

- To send by fax: Complete the form and send to (316) 978-3517.
- To send by mail: Office of Student Health Services
  1845 Fairmount
  Wichita State University
  Wichita, Kansas 67260-0092
  USA

Note: It is understood and intended that a telefacsimile transmission, scanned or photocopied copy of the original shall be of the same legal effect as the original.