MARY WALKER HEALTH CENTER

SUNY Oswego

Authorization for Treatment: For All Students Under the Age of 18

Student’s Name (please print clearly): _____________________________________________

Student’s DOB: _____ / _____ / _________

Signature of parent/guardian indicates SUNY Oswego Walker Health Center has permission to provide medical care or emergency treatment for your child. This indicates care and treatment by other consultants, if deemed necessary.

_________________________________________    _______________________________________
Signature of Parent/Guardian                      Parent/Guardian Name (please print)  

(____) ______________________________________ (____) ______________________________
Daytime Phone Number                              Home Phone Number (if different)

_________________________________________
Address