MEDICAL CARE AUTHORIZATION

"I, the undersigned, hereby specifically authorize Salve Regina University Health Services and/or any authorized member of the staff, or duly affiliated consultant, to provide care in the University Health Services, and for emergency treatment."

IF UNDER 18 YEARS OF AGE, PARENTAL SIGNATURE IS ALSO REQUIRED

Student Signature: _____ Date: _____

Parent Signature: _____ Date: _____