Oakwood University
Consent to Treat

(A Parent or Legal Guardian's signature is required if the student is under 19 years of age.)

I, the undersigned, do hereby authorize Oakwood University Health and Counseling Services (their agencies, consultants, and area hospitals) to perform any diagnostic or therapeutic examinations, procedures or treatments deemed necessary in the case of illness or injury. This consent is given in advance to allow the staff to exercise their best judgment in providing prompt medical services, the release of pertinent medical information, and the administration of required immunizations to Oakwood University students (if such immunizations have not been completed, or proof of completion is lacking).

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Address: _____

Phone (day): _____ (evening) _____ (cell) _____

***In case of Emergency the following persons are subject to be notified: parents, resident hall deans, student services administration and OUPD.**

_____ _____

Student Name (Print) *Student ID #*

_____ _____ _____

Student Signature: *Age* *Date*

_____ _____ _____

Parent/Guardian Signature *(required if student is under 19)* *Print Name of Parent/ Guardian* *Date*

*****PLEASE COMPLETE THESE FORMS AND RETURN PRIOR TO REGISTRATION *****

Fax – (256)726-7471

Email – ouhs@oakwood.edu

Mail – Oakwood University Health Services, 7000 Adventist Blvd, Huntsville, AL 35896