## CORNERSTONE UNIVERSITY HEALTH SERVICES AUTHORIZATION TO TREAT

I authorize Cornerstone University Health Services to administer medical services and/or to defer treatment to a local physician or medical facility if deemed necessary. In addition, I consent to Cornerstone University Health Services sending me a copy of my immunization records upon my request via mail, e-mail or fax, while I am a student at Cornerstone University.

Student: Print Name (first, middle initial, last)	Cornerstone ID#
Signature	Date
Are you under the age of 18?	
Your parent or guardian MUST sign below.	
Parent/Guardian Signature	Date
Relationship to student	
**************************************	
Attach a copy of the <u>front</u> side of family insurance card here	Attach a copy of the <u>back</u> side of family insurance card here
Front of Card	Back of Card