ETSUHealth
UNIVERSITY HEALTH CENTER

PERMISSION TO TREAT

Patient under the age of 18

I, _____, certify that I am a parent or guardian of (***Student's Name***): _____ (***Student's date of birth***) _____, and do hereby give permission to ETSU University Health Clinic to examine and treat my dependent child or ward. I understand that this examination and treatment is performed by certified Nurse Practitioners and Registered Nurses of the ETSU University Health Center and, on occasion, may be provided by the precepting physician of the ETSU University Health Center.

_____ _____
Signature of Parent or Guardian Date

_____
Printed Name of Parent or Guardian

_____ _____
Witness Date