LAKE SUPERIOR
STATE UNIVERSITY

Health CARE Center
650 W. Easterday Ave.
Sault Ste. Marie, MI 49783

CONSENT TO TREAT MINORS

In the event my child/dependent, _____, reports
Print Name Birth date
to the LSSU Health CARE Center for medical care, I do herby consent to such clinical care, including diagnostic procedures and medical treatment deemed appropriate by the Health Center medical staff.

I also authorize LSSU Health CARE Center to release health and accident information to any physician, hospital, or other medically related facility involved in my child's/dependents treatment, in addition to such information as may be necessary for completion of the my child's/dependent's insurance claims as a result of treatment received at the LSSU Health CARE Center.

_____
Print Name of Parent/Guardian

_____ _____
Signature of Parent/Guardian Date