The College of the Holy Cross Health Services
One College Street
Worcester, MA 01610

AUTHORIZATION TO TREAT A MINOR

To be completed by your parent/guardian

Note: Without a signed authorization by parent/guardian, Health Services cannot treat this student.

Student Name _____

Date of Birth _____

Medical Care Authorization:

I hereby give consent for my minor child,_____ to receive routine care through the Holy Cross Health Service and, in the event of an emergency, give permission to the Health Service and its affiliated hospital to secure for this child appropriate treatment, including orders for surgery and anesthesia if necessary.

Parent Signature _____

Printed Name_____

Address_____

_____

Phone number_____

Date_____