FERRIS STATE UNIVERSITY
Birkam Health Center

CONSENT TO TREAT MINORS

In the event that my child/dependent, _____,
Print Name **Birthdate** **Student #**
reports to the Birkam Health Center at Ferris State University for medical care, I do hereby consent to such clinic care, including diagnostic procedures and medical treatment deemed appropriate by the Health Center medical staff.

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

If my child/dependent does not have insurance at the time of his/her visit to the Birkam Health Center, or my child/dependent has insurance the Health Center does not accept as payment, I agree to be responsible for the payment of any services rendered by the Health Center staff on behalf of my child/dependent.

_____ _____
Signature of Parent/Guardian Date

_____
Print Name of Parent/Guardian