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. I authorize that my typed signature is equally binding as a written signature.

_____ _____

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

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HEALTH INSURANCE INFORMATION

Attach a copy of the front side of family insurance card here

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Health Services 1001 E Beltline Ave NE Grand Rapids, MI 49525
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E-mail: health.services@cornerstone.edu Web: https://www.cornerstone.edu/campus-health-services