

**Authorization for treatment  
For students under the age of 18**

Student Name \_\_\_\_\_ Birthdate: \_\_\_\_\_ Student ID# \_\_\_\_\_

I hereby grant permission to the Wellness Center and Counseling Center of Embry-Riddle Aeronautical University or the University Physician(s), Nursing staff or Mental Health Counselors to render any physical or mental health care OR emergency treatment to my son/daughter/ward. I also grant permission for the above referenced ERAU staff to arrange for health care, emergency treatment or hospitalization at an accredited hospital or other medical, psychological or dental care facilities when considered necessary by the Wellness Center staff or University Physician(s).

Student Signature \_\_\_\_\_ DATE \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ DATE: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Parent/Guardian Phone Number \_\_\_\_\_

Please email this form to [prwellnesscenter@erau.edu](mailto:prwellnesscenter@erau.edu) or fax to 928-777-3850.



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