ERAU WELLNESS CENTER PRESCOTT

NAME_____BIRTHDATE_____
BOX#_____ STUDENT ID#_____ PHONE#_____
DRUG ALLERGIES_____
SPECIALMEDICAL PROBLEMS_____
MEDICATIONS_____

I, HEREBY GIVE PERMISSION TO ERAU WELLNESS CENTER'S MEDICAL/NURSING STAFF TO ASSESS MY CONDITION, DISPENSE ANY MEDICATIONS AND TREATMENTS THAT MAYBE NECESSARY.

SIGNATURE _____ DATE_____