

OWAT Emergency Form

MEDICAL TREATMENT RELEASE

I hereby grant officials of the College for Creative Studies (CCS) permission to authorize emergency medical treatment, care and services while I am enrolled at CCS.

I fully understand that authorization in no way relieves me of any financial or other obligations related to decisions made by CCS officials and agree to be responsible for all incurred medical expenses. In the event that CCS incurs expenses for medical treatment, I agree to reimburse CCS in full.

Student: _____ Date: _____

Parent or Guardian: _____ Date: _____
(if student is under 18)

LOCAL DOCTOR*** (optional)

Name of Doctor _____ Phone Number _____

Address _____

AUTHORIZED PICK UP

Please list name and contact phone numbers for people authorized to pick your child up from CCS.

Name	Daytime phone #	Relationship
------	-----------------	--------------

Name	Daytime phone #	Relationship
------	-----------------	--------------

Name	Daytime phone #	Relationship
------	-----------------	--------------