



Consent to Treat

I, _____, give VSU Student Health Center permission to treat _____.

Guardian Signature _____ Date _____

Student Signature _____ Date _____

Student VSU ID# _____

Notary _____

Date _____

Student Health Center

Address 200 Georgia Avenue • Valdosta, GA 31698-0375

Phone 229.333.5886 • Fax 229.249.2791

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