



GUAMCOMMUNITYCOLLEGE

SCHOOL OF TECHNOLOGY & STUDENT SERVICES

Health Services Center

Phone: (671) 735-5586/5644/8889 Fax: (671) 734-8330

I, _____, give my free and full consent to the Guam Community College
(Please print your name)

Health Center's personnel staff to perform such necessary exams and treatment deemed advisable in connection with the maintenance of my wellbeing.

I understand that I will be briefed on each first aid, emergency medical care procedure and treatment that I will receive. I understand that I can ask questions. I understand that I have voluntarily requested care. I understand that it is my responsibility to supply accurate and complete medical history information to those involved with my care and to inform them of any changes in my health as soon as possible. I furthermore understand that it is my responsibility to inform those involved with my care if I do not understand any instructions given or if I am unable to comply with them.

This consent, unless sooner revoked in writing, shall expire upon my resignation, retirement, or dismissal from the Guam Community College.

Print Full Name

Signature

Date