Tel: 845-434-5750
Fax: 845-434-4806

UNDER 18 CONSENT FORM

To: Parents and guardians of students under 18 years of age

To avoid delay in treatment interventions, please sign the authorization below for medical or emergency treatment and have it notarized by a Notary Public. **PLEASE RETURN THE FORM TO THE SUNY SULLIVAN STUDENT HEALTH SERVICES OFFICE.** This consent for treatment applies only to care given at Student Health Services. Should the student seek or be referred for care at an off-campus facility, the policies and procedures of that facility will be followed.

It is the policy of Student Health Services that student medical records are confidential. No information is released without written authorization of the student except in some emergency or public health situations or under a court-ordered subpoena.

CONSENT OF PARENT OR GUARDIAN FOR MEDICAL OR EMERGENCY TREATMENT

I,____, pursuant to the authority vested in me as
(Name of Parent or Guardian)

____ of ____,
("Parent" or "Guardian") (Name of Student)

do hereby authorize a practicing physician or nurse practitioner to exercise, for me and on my behalf, all my rights and duties with reference to consenting to appropriate medical, surgical or hospital treatment deemed necessary for the medical or emergency care of my child.

Date of student's birth______________________
(month/day/year)

Signed__________________________________ Date__________________________
(Signature of Parent or Guardian)

Notary Public____________________________ Date__________________________