SUNY Sullivan
Student Health Services
112 College Road
Loch Sheldrake, NY 12759
(845) 434-5750 ext. 4247
Fax: (845) 434-3628
Email: Healthservices@sunysullivan.edu

Please Return to Health Services

UNDER 18 CONSENT FORM

To: Parents and Guardian of student 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 THIS FORM TO THE SUNY SULLIVAN HEALTH SERVICES OFFICE. This consent for treatment applies only to care given at the Student Health Services office. 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 the Student Health Services Office that student medical records are confidential. No information is released without written permission of the student except in some emergency or public health situations or under a court order subpoena.

CONSENT OF PARENT/GUARDIAN FOR MEDICAL OR EMERGENCY TREATMENT

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

____ of _________________________________,
(Relationship to student) (Student Name)

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.

Student's Date of Birth:_____________________________________

Parent/Guardian PRINTED Name:___________________________________

Parent/Guardian Signature:____________________________________ Date:________________

Notary Public:____ Date:_________________