UNDER 18 PERMISSION TO TREAT

SUNY Delhi

Student: Birthdate:

Preferred Phone Number: (   )

Emergency Contact Name: Preferred Phone Number: (   )

SUNY Delhi ID # 800

PERMISSION FOR SHS TREATMENT FOR STUDENTS UNDER 18 YEARS OF AGE

To avoid delay in treatment when medical problems arise, we request that the following statement be signed by a parent or legal guardian:

I hereby grant permission to the practitioners and nurses at SUNY Delhi Student Health Service to evaluate, treat, or secure a referral to an outside agency for student name ________________________ in case of illness/injury. I also hereby grant permission to immunize above name student in cases where immunization is necessary as part of a treatment plan, required by the program they are enrolled in, or

when needed for prevention of illness.

____   ________________________

Parent/Guardian Signature Relationship Date

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.

Return this form to:

SUNY Delhi
454 Delhi Drive
Delhi, NY 13753

Fax to: (607)-746-4141 email: healthservices@delhi.edu