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 the University at Albany 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 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.