Under 18 Permission to Treat

University at Albany Student Health Services

UNIVERSITY AT ALBANY
State University of New York

Student: ____ Birthdate: ____ / ____ / ____
Last First M.I. Month Day Year

Preferred Phone Number: (   ) ______________________ UAlbany ID # ______________

Emergency Contact Name: ______________________ Preferred Phone Number: (   ) ______________

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.

Return this form to:

University at Albany, Student Health Services
1400 Washington Ave, Albany, NY 12222
(518) 956-8400. Or fax to: (518) 442-5444 email: healthforms@albany.edu

Any additional medical summaries (or other pertinent information) that incoming students, parents or medical practitioners view as appropriate for inclusion in the student's UAlbany Student Health Services medical record should be sent directly to Student Health Services.