EST. 1908

SUNY MORRISVILLE

ATTENTION: FOR STUDENTS *UNDER EIGHTEEN* (18)

CONSENT TO TREAT

In order to provide routine and/or emergent care that may be necessary for students and at the same time to protect the providers and institutions involved, please complete and sign below:

I,_____do hereby authorize the medical and counseling staff of

PARENT/GUARDIAN *PLEASE PRINT NAME*

SUNY Morrisville's Student Health Center to provide routine care to my son/daughter. This care may include treatment for common illnesses and injuries, physical examinations for participation in sports or clinical rotations, ordering of laboratory tests, prescribing/dispensing of medications, or an initial counseling consultation if initiated by the student. I also give permission to local emergency room departments and their physicians, to provide appropriate medical, psychiatric, and surgical treatment, including anesthetics, as medically indicated in case of emergency for my son/daughter.

PRINTED FULL NAME OF STUDENT

STUDENT'S DATE OF BIRTH

PARENT/GUARDIAN WRITTEN CONSENT _____ DATE _____