FREDONIA
STATE UNIVERSITY OF NEW YORK

STUDENT HEALTH CENTER

PERMISSION FOR TREATMENT OF STUDENTS UNDER 18 YEARS OF AGE

Name of Student: _____
Fredonia ID: _____

For parents/guardians of Applicants under 18 years of age: In order to provide routine and/or emergent medical care, please sign the consent below. Be assured that we make every effort to notify parents at once in case of major injuries or serious illness.

I (your full name)_____pursuant to the authority vested in me as the parent/guardian of (student's full name) _____
Do herby authorize the clinical staff at the State University of New York at Fredonia's Student Health Center to provide routine medical care to my son/daughter. This care may include treatment for common illnesses, physical examinations for sports participation, ordering of laboratory tests, prescribing of medications and the administration of immunizations to meet New York State immunization requirements. Furthermore, I do hereby authorize the clinical staff of the State University of New York at Fredonia to seek emergency medical care from outside clinicians if they feel it is necessary.

Signed
(parent/guardian)_____Date:_____