



Medical Treatment Authorization for Minors

Treatment Authorization: To be signed by a parent or guardian, if a student is under 19 years of age.

I authorize and give my consent to Health Services of Union College to perform upon or administer to:

Student's Legal Name (please print): _____

any necessary medical or surgical treatment. This authorization is good only while the student is attending Union College and only until the student has attained his/her 19th birthday. I also give my permission to administer whatever anesthetic may be necessary or advisable during medical or surgical procedures.

This authorization is intended to cover emergency measures, immunizations, injections, and minor operations and procedures, and in the event of an indicated major operation, the College authorities will attempt to contact me by phone/text/or email before relying upon this authorization. It is not intended that any medical or surgical treatment will be rendered to the student without his/her personal consent, except in emergency (i.e., unconsciousness).

In addition, I give authorization for the student to receive mental health counseling services.

Due to SARS-CoV-2 virus or any other rapidly spreading disease or condition, physical and mental health visits may also be conducted virtually through secure HIPAA compliant sites such as Tele Health or Tele Mental Health appointments.

Permission is also granted to release information from the student's health record to person/s designated by the College when in the opinion of Campus Health, release of specific information is deemed necessary for the safety of the student or others.

Parent/Guardian Name (please print) _____

Parent/Guardian Signature _____ **Relationship to student** _____

Date Signed _____ **Phone Contact of Parent/Guardian** _____

Parent/Guardian Address _____

Parent/Guardian email _____