# Permission to Treat for Minors Under 18 Years of Age

(to be completed by student's parent/guardian)

*I give permission for my child/ward (student name)* _____
*to receive primary care, counseling, or urgent care from the staff at University Health Service and/or Strong Memorial Hospital in the event of injury or illness. I understand I will be responsible for all charges for services not covered by the health fee.*

*I certify that I have received both the Notice of Privacy Practices and information about the risks, benefits, availability, and alternatives to Meningococcus Vaccination.*

Name of Parent/Guardian – please print

_____

Relationship

_____

Primary Phone:

_____

Secondary Phone:

_____

Email:

_____

Date

_____

Signature of Parent/Guardian

_____

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