



Medical Treatment Authorization

TREATMENT AUTHORIZATION: To be signed by parent or guardian, if 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 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 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.

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 the Director of Campus Health Services, release of specific information is deemed necessary.

Parent/Guardian Name (please print) _____

Relationship to student _____

Parent/Guardian Signature _____ Date _____

Address _____

Parent/Guardian Phone Contact _____

Parent/Guardian email _____

To complete this item on your Registration Checklist, please submit it through your student portal webpage under "Health Documents".

Updated 11-8-2017