Potsdam
STATE UNIVERSITY OF NEW YORK

Student Health Services
119 Van Housen Hall

CONSENT FOR THE TREATMENT OF MINORS

I, _____, am the parent/guardian of _____, who is currently a minor (under age 18). I authorize SUNY Potsdam Student Health Services to provide medical care to my dependent, including but not limited to diagnostic procedures, medical treatment, and administration of medications deemed appropriate by the medical staff.

I understand that if an injury/illness is determined to require urgent intervention, an ambulance will be called to take my dependent to the nearest hospital.

I understand that medical services provided outside of SUNY Potsdam Health Services (i.e. at pharmacies, laboratories, hospitals) are subject to my health insurance benefits plan including applicable copays and/or deductibles. I understand that there are fees for some services (such as vaccinations or in-house laboratory testing) at Health Services. I agree to be responsible for the payment of any services rendered by Health Services not covered by my dependent's health insurance.

I understand that once my dependent reaches age 18, my consent for treatment is no longer required.

By my signature, I acknowledge that I have read and understood this consent and grant permission for SUNY Potsdam Health Services to treat my dependent.

_____ _____
(Parent/Guardian's Signature) (Date)

_____ _____
(Print Name of Parent/Guardian) (Relationship to student)

Please return the completed form using one of the following methods:

Mail to:
SUNY Potsdam
Student Health Services
44 Pierrepont Ave.
Potsdam, NY 13676

Fax to: *315-267-3260*

Email to: *SHS@potsdam.edu*