Authorization for Treatment of a Minor

RETURN BY MAIL TO: Iona College, Health Services
715 North Avenue
New Rochelle, NY 10801

(Complete this form only if student will be under the age of 18 while at Iona College.)

Name: _____
First Middle Last

Date of Birth: _____/_____/_____ Student I.D. #: _____
Month Day Year I.D. Number on your admissions contract

Permanent Address: _____

Local Phone: (_____) _____ Permanent Phone: (_____) _____

Person to Notify in Case of Emergency: _____

Relationship: _____ Phone Number: (_____) _____

Insurance Company: _____

Policy Number: _____ Insurance Co. Phone: (_____) _____

TO PARENTS OR LEGAL GUARDIAN

If your son, daughter, or ward will be under the age of 18 years while at Iona College, it is our policy to secure your consent for medical treatment. By signing the form below, you will be giving your consent for any medical evaluation and treatment necessary to ensure the continued health of the student. In the event of a major health problem, whenever possible, specific permission will be obtained from you.

AUTHORIZATION FOR TREATMENT OF A MINOR

I,_____, being the parent or legal guardian of _____ , give my consent to Iona College Health Services, the physicians and other personnel on its medical staff, to administer such care, procedures and treatment that is deemed necessary and in the best interest of the patient. As long as the medical or surgical treatment considered necessary in the situation is in accordance with the generally accepted standards of medical practice for the particular type of injury or illness involved, I impose no specific limitations or prohibitions regarding treatment other than those that follow (if none, so state):

I understand that this authorization is good until the time in which the minor mentioned above reaches his/her 18th birthday.

Signature: _____ Date: _____
Parent or Guardian

Address: _____ City: _____ State: _____ Zip: _____

Witness: _____ Phone: (_____) _____ (_____) _____
Daytime Evening