College of Staten Island
The City University of New York
Health & Wellness Services

# Authorization for Treatment of a Minor

**(Complete this form only if student will be under the age of 18 while attending CSI.)**

Name: _____
First Middle Last

Date of Birth: ____/____/____ EMPL ID: _____
Month Date Year

Address: _____

Telephone: _____ Cell: _____

Person to Notify in Case of Emergency: _____

Relationship: _____ Telephone/Cell: _____

***TO PARENTS OR LEGAL GUARDIAN:***

If your son, daughter or ward will be under the age of 18 while attending CSI, you have the option to consent, by signing this form, for your child to receive medical evaluation and treatment necessary to ensure the continued health of the student. Consent will be for evaluation and treatment at the College of Staten Island, Health and Wellness Services only. 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 the College of Staten Island, Health and Wellness Services, the physicians, nurses and nurse practitioners, to administer such care, procedures and treatment that is deemed necessary and in the best interest of the student. As long as the medical treatment is 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: _____

Address: _____ City: _____ State: ____ Zip code: _____

**Health and Wellness Services, 1C - Room 112, 2800 Victory Blvd., Staten Island, NY 10314**
**Telephone: 718.982.3045 Fax: 718.982.2966**

*Revised 10/2015*