

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:	Month Date	Year EMPL	ID:		
Address:					
Telephone: _		Cel	l:		
Person to Not	ify in Case of Eme	rgency:			
Relationship:	ationship: Telephone/Cell:				
TO PARENTS	OR LEGAL GUARD	IAN:			
by signing thi continued hea Health and V	s form, for your alth of the studen	child to receive medical t. Consent will be for eval only. In the event of a	evaluation and treatme uation and treatment at	have the option to consent, nt necessary to ensure the the College of Staten Island, whenever possible, specific	
	AUTHORIZATION FOR TREATMENT OF A MINOR				
l,			being the	e parent or legal guardian of	
treatment tha is considered practice for the	it is deemed nece necessary in the he particular type	ins, nurses and nurse pra ssary and in the best inter situation, is in accordanc	ctitioners, to administer rest of the student. As loo e with the generally acc ved, I impose no specific	of Staten Island, Health and such care, procedures and ng as the medical treatment epted standards of medical c limitations or prohibitions	
I understand his/her 18 th bi		zation is good until the t	ime in which the minor	mentioned above reaches	
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: 646.664.3987