Permission to Treat Underage Student/Patient

For Patients/Students Aged 17 and Under
Please Print

Student/Patient's Name: _____
Last First MI

Date of Birth: _____ Student ID#: _____

Parent/Legal Guardian's Name: _____
Last First MI

Street Address _____

City_____ State _____ Zip _____

Relationship to this student/patient: _____

Phone contact number: (_____) _____

Permission to Treat

I give my permission for licensed health professionals at the University of New Hampshire Health & Wellness to provide care/treatments to my daughter/son/ward named above. This includes examination, minor medical procedures, emergency treatment, massage therapy, and administration of medications/required immunizations/desired inoculations if reasonable and appropriate.

Parent/Guardian Signature_____ Date_____

Student's/Patient's Signature _____

Notice of Privacy Practice

I consent to using and disclosing health information for treatment, payment, or healthcare operations and have received, read, and understand the Notice of Privacy Practices.

_____ _____
Parent/Guardian Signature *Student/Patient Signature*

Patient Rights and Responsibilities

I have received, read, and understood the Patient Rights and Responsibilities document.

_____ _____
Parent/Guardian Signature *Student/Patient Signature*