Farmingdale State College
State University of New York

Under 18 Permission to Treat
Health and Wellness Center

Name: _____
Last First Middle

Phone Number :_____ **Student RAM ID#**_____ **Date of Birth:** _____/_____/_____

Emergency Contact Name: _____ **Phone Number:**_____

PERMISSION FOR TREATMENT FOR STUDENTS UNDER 18 YEARS OF AGE

To avoid delay in treatment when medical problems arise, we request that the following statement be signed by a parent or legal guardian:

I, _____, hereby grant permission to the practitioners and nurses at the Farmingdale
(insert parent/guardian name)

State College Health and Wellness Center to evaluate, treat, secure a referral to an outside agency and/or hospitalize

my child, _____, in case of illness or injury.
(insert child's name)

_____ **Date:**_____
Parent/Guardian Signature Relationship

It is the policy of FSC Health and Wellness Center that student medical records are confidential. No information is released without written authorization of the student except in some emergency or public health situations or under a court-ordered subpoena.

RETURN THIS FORM TO:

Farmingdale State College Health and Wellness Center
2350 Broadhollow Road, Farmingdale. NY 11735
934-420-2009 or fax to 934-420-2137
Email: wellness@farmingdale.edu

Any additional medical summaries (or other pertinent information) that incoming students, parents or medical practitioners view as appropriate for inclusion in the student's Farmingdale State College Health and Wellness Center medical record should be sent directly to The Health and Wellness Center.

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