Cayuga HEALTH | ITHACA COLLEGE Student Health Services

Please complete this form and return to: Health Certifications, Cayuga Health at Ithaca College, 953 Danby Road, Ithaca, NY 14850 **OR Fax to:** (607) 274-1844

Consent for Treatment of a Minor

PERMISSION FOR MEDICAL CARE

To be completed only for students under 18 at the time of matriculation:

Student's Name (please print): _____

Ithaca College ID Number: _____ _____ _____ - _____ _____ _____ - _____ _____ _____

I hereby give permission to the medical staff of Cayuga Health at Ithaca College to examine and treat my son or daughter (print student name) _____, for all medical problems and injuries occurring while they are at school. Furthermore, in the event that time will not allow me to be reached, or that I cannot be reached, I hereby give permission for the College Health Center physicians to secure necessary consultative care for my child, to include hospitalization, anesthesia, surgery, and other indicated treatment.

Name (please print): _____

Signature: _____ Date: _____
(parent/guardian)

PERSON TO NOTIFY IN CASE OF EMERGENCY

_____

Name (last, first) Relationship

_____

Address

_____

City State Zip

_____

Home Telephone Cell/Business Telephone

Ithaca College Student Health Services, 953 Danby Rd., Ithaca, NY 14850

Privacy Official: 607-274-3177

Please review out "Notice of Privacy Practices" which describes how medical information may be used and disclosed and how you can get access to this information.

Notice of Privacy Practices Receipt

I acknowledge that I was provided with the "Notice of Privacy Practices" of the medical practice names at the top of this page. Please complete this notice of privacy practices receipt and sign both the receipt and the consent below.

Print Name of Student: _____

Student's Ithaca College ID: _____

Student's Date of Birth: _____

Date: _____

Please check if you are under 18: ☐

For Personal Representative of the Student (if a minor):

Print Name of Personal Representative: _____

Describe Personal Representative
Relationship (parent, guardian, etc.): _____

Signature of Personal Repetitive: _____

Date: _____

Consent for Purposes of Treatment, Payment, or Health Care Operations

I consent to the use or disclosure of my protected health information by the Ithaca College student health services staff for the purpose of diagnosis or treatment, obtaining payment for health care services rendered, or in order to conduct health care operations.

I understand that I have the right to request a restriction or limitation on how and to whom my protected health information is used or discolored for the above purposes. The Ithaca College Hammond Health Center is not required to agree to such request, but if agreed upon, the center will comply unless the information is needed to provide me emergency treatment.

The "Notice of Privacy Practices" describes my rights as well as Ithaca College Hammond Health Center's rights and responsibilities with respect to my protected health information.

Signature of Student (or personal representative if a minor): _____

Name of Student: _____

Date: _____

MENINGOCOCCAL MENINGITIS VACCINATION REPSONSE FORM

New York State Public Health Law requires that all college and university students enrolled for at least six (6) semester hours or equivalent per semester, or at least four (4) semester hours per quarter, complete and return the following form to Cayuga Health at Ithaca College, 953 Danby Road, Ithaca NY 14850.

Check only one box and sign below.

I have, or my child (parent complete if child is a minor, under the age of 18) has:

☐ read, or had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I (my child) will **NOT** obtain immunization against meningococcal meningitis disease at this time.

Student's Signature: _____ Date: _____
(parent/guardian if student is a minor)

Print Student's Name: _____ Student's Date of Birth: _____

Student's Email Address: _____

Student's ID Number: _____

Student's Mailing Address: _____

_____

Student's Phone Number: _____