Health & Wellness Services
10 Upper College Drive
Alfred, NY 14802
Phone: 607-527-4200
healthandwellness@alfredstate.edu

HEALTH AND WELLNESS
PREMISSION FOR TREATMENT FOR STUDENTS UNDER 18 YEARS OF AGE

Name of Student: ____

Date of Birth: ______________________ Student ID# ___________________

For the parents/guardians of applicants under the age of 18 years of age:

- To provide routine and or emergent medical and mental health care (Mantra Health Telepsychiatry), please sign the consent below. Please be assured that we make every effort to notify parents at once in case of minor or serious injuries or serious illness

I (name of parent or guardian) ____
PLEASE PRINT

Pursuant to the authority vested in me as parent/guardian
of (students name) ____
PLEASE PRINT

I do herby authorize the health and mental health staff of the State University of Alfred's Health & Wellness office to provide routine medical care to my son/daughter. This care may include treatment for common illnesses ordering laboratory tests, prescribing of medication, and administration of medications. Furthermore, I do hereby authorize the staff of the State University of Alfred Health & Wellness to seek emergency medical care from outside the office if they feel it is necessary. Additional consent may be required at the time of the students visit.

Please Print Name: ____
Parent or Guardian

Please Sign Name: ____
Parent or Guardian

Date: ______________________________