

**State University of New York
at Canton
Davis Health Center**
Miller Campus Center 004
Canton, NY 13617
(315) 386-7333 Phone
(315) 386-7932 Fax

TO: Parents or guardians of students under eighteen years of age:

In order to procure medical care for your student and to avoid unnecessary delay, you are encouraged to sign the consent for medical treatment below and return the form to the Davis Health Center. Be assured that we make every effort to notify parents as soon as possible, in case of major injuries or serious illnesses.

I, _____,
(Parent/Guardian)

pursuant to the authority vested in me as the parent/guardian of

(Student's Full Name)

do hereby authorize the clinical staff at SUNY Canton's Davis Health Center to provide routine medical care to my son/daughter. This care may include treatment of common illnesses, physical examinations for sports participation, ordering of laboratory tests, prescribing of medications and the administration of immunizations to meet New York State immunization requirements.

Furthermore, I do hereby authorize the clinical staff of the State University of New York College at Canton to seek emergency medical care from outside clinicians if they feel it is necessary.

I understand that if my son/daughter participates in intercollegiate athletics, information about his/her medical condition and/or insurance coverage may need to be shared with the athletic training staff in order to ensure his/her safe participation in athletics. Any medical information not directly related to athletic participation will be kept confidential. My signature below includes authorization to release information to the athletic training staff as outlined above.

I understand I am free to withdraw this consent, in writing, at any time.

Signed: _____

Full Name (please print): _____

Date: _____