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) _____

Date of Birth: _____/_____/_____

Ithaca College Student ID Number: _____

I hereby give permission to the medical staff of Cayuga Health at Ithaca College to examine and treat my child listed above for all medical problems and injuries occurring while they are at school. Furthermore, in the event that time will not allow me or alternate contact to be reached, or that I/they cannot be reached, I hereby give permission for Cayuga Health at Ithaca College medical providers to secure necessary consultative care for my child, to include, but not limited to, hospitalization, anesthesia, surgery, and other indicated treatment.

Name of Parent/Guardian (please print): _____

Signature_____ Date_____/_____/_____

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name (last, first) Relationship

_____

Address

City State Zip

Primary Telephone Secondary Telephone

Alternate PERSON TO NOTIFY IN CASE OF EMERGENCY

Name (last, first) Relationship

_____

Address

City State Zip

Primary Telephone Secondary Telephone

Cayuga HEALTH | **ITHACA COLLEGE**
Student Health Services

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

Privacy Official: 607-274-3177

Please review our "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 disclosed 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 Representative if student is a minor: _____

Name of Student: _____

Date: _____

Cayuga HEALTH | ITHACA COLLEGE
Student Health Services

MENINGOCOCCAL MENINGITIS VACCINATION REPSONSE FORM

Ithaca College in accordance with New York State Public Health Law requires that all college and university students either receive vaccination for Meningitis, or complete and return the following form to Cayuga Health at Ithaca College, 953 Danby Road, Ithaca, NY 14850.

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.

https://www.cdc.gov/vaccines/hcp/vis/vis-statements/mening.html

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: _____