HAVERFORD
COLLEGE

CONSENT TO MEDICAL TREAT MINOR STUDENT PATIENT

Because Pennsylvania Law requires consent of parent/guardian for medical care of minors, if your dependent child is enrolled at Haverford College prior to his/her 18th birthday and you want their healthcare provided by Haverford College Health Services, you must first complete and return the following consent to:

Haverford College Health Services, 370 Lancaster Avenue, Haverford, PA 19041

- I,_____(print name here), am the parent/guardian of _____(print name of student), currently a minor,
- Date of birth of minor is ____/____/____.

I authorize Haverford College Health Services staff to provide medical care and/or mental health care to my child including, but not limited to, medications, diagnostic examinations (including radiological and laboratory testing), tuberculosis screening, verification and/or administration of immunizations, any necessary mental health counseling, medical treatment, and in the event of a major emergency, give lifesaving treatment and medication. For surgical procedures, or more extensive medical care, attempts will be made to contact me before such care is initiated.

I also understand that if the injury/illness is determined to be life threatening, and if according to the college staff's best professional judgment further delay might jeopardize my child's welfare, an ambulance will be called to take my child to the hospital and that the staff will make every effort to contact me. I understand that college officials will be notified of any serious illness or injury threatening my child's life.

I further understand that, once my child reaches the age of maturity, my consent for treatment is no longer required.

I understand I am required to maintain health insurance and am responsible for payment of any outstanding or unpaid medical charges and will be balance billed to my permanent address. I give permission to share health information with insurance carriers for processing payment and reimbursement purposes.

By signing this I acknowledge that I have read and understand this consent, and that any questions I had prior to signing could be answered by calling Student Health Services at 610-896-1089. I give permission to treat.

_____ _____

Signature Date

Emergency Phone Number:

- **Name (print):**_____
- **Home (phone)** _____
- **Work (phone)** _____
- **Cell**_____
- **Second contact name (print):** _____
- **Phone Number**_____

Revised 5-14, Updated 3/2017