

LE MOYNE

SPIRIT. INQUIRY. LEADERSHIP. *JESUIT*

Wellness Center for Health and Counseling

1419 Salt Springs Road
Syracuse, NY 13214-1301
315-437-4440 (Health Office)

***TO BE COMPLETED BY A PARENT/GUARDIAN
ONLY FOR STUDENTS WHO ARE UNDER
18 YEARS OLD AT TIME OF MATRICULATION.**

CONSENT FOR TREATMENT OF A MINOR AND PERMISSION FOR HEALTH AND COUNSELING

Please complete this form and return it with the other required forms.

Student's Name (please print): _____

Date of Birth: _____

I hereby give permission to the health and counseling staff at Le Moyne College Wellness Center to treat my son/daughter (or my student) for all physical or emotional problems (including injuries) occurring while he or she is at Le Moyne College. I hereby give permission for the College Wellness Center physicians and counselors to use any necessary curative care for my child to include hospitalization, anesthesia, surgery and other indicated treatment.

Parent or Guardian Name (please print): _____

Signature (parent or guardian): _____ Date: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE (WITH AREA CODE): _____

CELL/BUSINESS PHONE (WITH AREA CODE): _____