Authorization and Consent for Treatment of Minors

ILLINOIS STATE UNIVERSITY
STUDENT HEALTH SERVICES
201 N. University St, Campus Box 2540
Normal, Illinois 61790
Phone (309) 438-8655 Fax (309) 438-5205
Secure Electronic Submission: http://healthservices.illinoisstate.edu/medical-services/submitrecords.php

To be completed by parent or guardian if student is less than 18 years of age when seeking healthcare services from I.S.U. Student Health Services.

As the parent/legal guardian of (print student's name): _____,

I hereby authorize and give my express consent to ISU Student Health Services for the administration of medical treatment for illness or injury, physical or mental health counseling and routine health maintenance to the above-named student, without an adult present, as deemed necessary in the sole clinical discretion of members of ISU Student Health Service's professional staff. This staff includes, but is not limited to, physicians, nurse practitioners, physician assistants, registered nurses, licensed practical nurses, x-ray technologists and laboratory technicians. I further authorize and give consent to ISU Student Health Services to provide treatment, counseling or other routine care via telehealth services. I understand that the laws that protect privacy and confidentiality of health information also apply to telehealth services. This consent is good until the students' 18th birthday.

The following scope of services were explained to the legal guardian:

- Psychiatry/Mental Health
- Primary care/illness
- Sexual Health/Birth Control
- Dietary
- Gynecological services
- Minor procedures such as but not limited to laceration repair and I&D of abscess
- Labs
- X-Rays
- Immunizations:
  - MMR
  - Hep B
  - Hep A
  - Tdap/Td
  - Meningitis ACYW and Meningitis B
  - Influenza
  - Gardasil
- Pharmacy Needs

Student's Date of Birth: _____

Student's University Identification Number: _____

Place Patient Label here

Authorization and Consent for Treatment of Minors

_____ _____

Signature (Parent/Legal Guardian) Date

_____ / _____

Printed Name (Parent/Legal Guardian) ***Relationship to student***

_____

Phone Number (Parent/Legal Guardian)

_____

Alternate Phone Number (Parent/Legal Guardian)

_____

Witness (if applicable)

_____

Second Witness (if applicable/ phone consent)

Place Patient Label here