

SALISBURY UNIVERSITY STUDENT HEALTH SERVICES

PARENTAL CONSENT FORM Return by mail, fax or email:

Salisbury University Student Health Services, Holloway Hall Room 180, 1101 Camden Avenue, Salisbury, MD 21801

FAX: 410-548-4101 • EMAIL: studenthealth@salisbury.edu

Name: (Last) _____ (First) _____ (MI) _____

SU Identification Number: _____ Date of Birth: _____

Permission to Treat a Minor

A parent or guardian of any student under the age of 18 must provide consent by reading and signing the statement below.

- I hereby grant permission to Student Health Services to render medical care to my dependent.
- I understand that a minor over the age of 16 may give his/her own consent for certain kinds of medical care, including treatment for mental health issues or issues related to sexuality (e.g. pregnancy, sexual assault) and parents/guardians may not be notified.
- I understand that medical information may be obtained from or given to medical professionals involved in the care of my dependent.

Printed Name of Parent/Guardian

Signature of Parent/Guardian

Relationship to Student

Date of Consent