EMORY UNIVERSITY | Student Health and Counseling Services

CONSENT FOR TREATMENT

Student Name: _____ Student ID #:_____

I hereby consent to receive medical care (or for my minor child or ward under 18 years of age to receive medical care) from Emory University Student Health Services, or from the professional staff of any other Emory Healthcare facility, including but not limited to The Emory Clinic, Emory University Hospital and Crawford Long Hospital of Emory University. I also authorize such treatment, x-rays or other diagnostic studies as, in the judgment of the attending physician, may reasonably be necessary to preserve and protect my health (or the health of my minor child or ward).

If you are under 18 years of age, please print off this form for your parent or guardian to sign.

_____ _____

Signature of Student ***Date***

If the student is under 18 years of age, this form must be signed by the parent or guardian:

_____ _____

Signature of Parent or Guardian ***Date***

This is a paper version of a form that is now completed electronically via *Your Patient Portal* at https://www.shspnc.emory.edu/login_directory.aspx. If you need to use this paper version of the form, please be certain that all signatures are completed. Mail this completed form to:

Director of Nursing Services
Emory University Student Health and Counseling Services
1525 Clifton Road
Atlanta, GA 30322

Paper version 7/2010