SBU Student Signed Consents

PERMISSION FOR TREATMENT OF STUDENTS UNDER 18 YEARS OF AGE

When serious medical problems arise, every effort will be made to reach parents, guardians or spouse. On occasion, we are unable to make this contact. To avoid delay in treatment, we request that the following statement be signed by a parent, guardian or spouse.

I hereby grant permission to treat and / or hospitalize my son/daughter/spouse/ward incase of illness or injury.

Signature of Parent or Guardian or Spouse _____ Date ___/___/___

Relationship To Student _____

**** Note to Athletes: Your signature authorizes the release of this information between the Center for Student Wellness and the athletic training staff at St. Bonaventure University.**

Student Athlete Signature _____ Date ___/___/_____

PERMISSION TO RELEASE MEDICAL INFORMATION

I hereby grant permission to the of St. Bonaventure University Center for Student Wellness to release information to Campus Security, Residence Life staff, Counseling Services, Ambulance Personnel, and Olean General Emergency Department personnel if needed, and in the best interest of my health and safety.

_____ ____/____/_____

Student's Signature Date

_____ ____/____/_____

Parent's Signature IF student is under 18 years of age Date

I_____ hereby grant permission for the Center for Student Wellness Health Service Department at St. Bonaventure University to release information concerning my medical care to the following persons.

_____		_____	
Name	Parent	Name	Relationship
_____		_____	
Name	Parent	Name	Relationship
_____		_____	
Name	Relationship	Name	Relationship

_____ _____/_____/_____

Signature of Student Date