AUTHORIZATION FOR THE TREATMENT OF MINORS

GOUCHER college

STUDENT HEALTH CENTER

1021 Dulaney Valley Rd., Baltimore, MD 21204
Phone: (410)337-6050
Fax: (410)337-6051
Upload completed & signed form to:
https://goucher.medicatconnect.com

Student Name & pronouns _____ Date _____

Date of Birth _____ Student ID Number _____

If the student has not yet reached their 18th birthday before moving onto Goucher College's campus or beginning the academic year, the following authorization by a parent or legal guardian is required.

I hereby grant permission to Goucher College to proceed with any needed medical treatments for the above named student. In the event of serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made by the medical provider to contact me in the most expeditious manner possible. If said provider is unable to communicate with me, I authorize the staff to provide or secure necessary emergency treatment for the best interest of the above named student. _____ (initial here)

Additionally, I give permission for the above named student to receive immunizations through on campus clinics run by community partners such as health departments or retail pharmacies (i.e. flu shot clinics). _____ (initial here)

Parent/Guardian signature _____ Date _____

Printed Name _____ Relationship to Student _____

Home Phone Number _____ Work Phone Number _____