NYU Student Health Center

Authorization for Treatment of a Minor

RETURN BY MAIL TO:

NYU Student Health Center • Health Information Management Services
726 Broadway, Suite 340, New York, NY 10003-9580

(Complete this form only if student will be under the age of 18 while at NYU.)

Name: _____
First M.I. Last

Date of Birth: ____/____/____ Student I.D. #: N_____
Month Day Year 8-digit number on back of I.D. card

Local Address (while at NYU): _____

Permanent Address: _____

Local Phone: ( ) _____ Permanent Phone: ( )_____ Cell Phone: ( )_____

Emergency Contacts:
Contact 1_____Relationship:_____ (C) _____ (W)_____ (H)_____

Contact 2_____Relationship:_____ (C) _____ (W)_____ (H)_____

For services typically covered by insurance, SHC will bill your health insurance plan.
You are responsible for knowing what your respective insurance plan will and will not cover.

☐ NYU Student Health Insurance – check box. If not, fill in information below.

Insurance Company: _____

Policy Number: _____ Insurance Co. Phone: (___) _____-_____

To Parents or Legal Guardian

If your son, daughter, or ward will be under the age of 18 years while at New York University, it is our policy to secure your consent for medical treatment. By signing the form below, you will be giving your consent for any medical evaluation and treatment necessary to ensure the continued health of the student. In the event of a major health problem, whenever possible, specific permission will be obtained from you.

Authorization for Treatment of a Minor

I, _____, being the parent or legal guardian of _____, give my consent to NYU Student Health Center, the physicians and other personnel on its medical staff, to administer such care, procedures and treatment that is deemed necessary and in the best interest of the patient. As long as the medical or surgical treatment considered necessary in the situation is in accordance with the generally accepted standards of medical practice for the particular type of injury or illness involved, I impose no specific limitations or prohibitions regarding treatment other than those that follow (if none, so state):

_____

I understand that this authorization is good until the time in which the minor mentioned above reaches his/her 18th birthday.

Signature:_____ Date: _____
Parent or Guardian

Address: _____City: _____State: _____Zip: _____

Witness: _____Phone: (_____)_____ (_____)_____
Daytime Evening