Consent for Medical Treatment of a Minor

Student name: _____

I hereby grant permission to the Roger Williams University Health Services staff to provide appropriate medical treatment including coordination of care among clinicians, medication for treatment of illness/injury and to arrange for any emergency medical care if circumstances at that time make it impossible for me to make such decisions.

I understand that Health Services may disclose information from my medical records to appropriate University staff and/or family and/or emergency contacts in the case of a health or safety situation as deemed necessary by Health Services staff.

I certify that to the best of my knowledge the information I am submitting to the Student Health Portal is complete and correct.

This authorization will remain in effect as long as I am a student at Roger Williams University.

Signature below indicates understanding of and agreement with the above information.

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

(REQUIRED if student is under 18 years of age)