**PLEASE RETURN TO:**
**SUNY OLD WESTBURY**
**STUDENT HEALTH CENTER**
**P.O. BOX 210**
**OLD WESTBURY, NY 11568**
**PHONE: (516) 876-3250 FAX: (516) 876-3142**
**EMAIL: studenthealth@oldwestbury.edu**

# AUTHORIZATION FOR A MINOR CHILD

(A student is considered a minor if they are under the age of 18 at the time of residence hall check-in or the start of classes, whichever comes first)

I (We), _____ and _____ (full names of custodial parents/legal guardians), am (are) the parent(s)/legal guardian(s) of:

**Minor Child's Full Legal Name**: _____

Home Address: _____

Date of Birth (MM/DD/YYYY): _____/_____/_____

SUNY Old Westbury ID #: _____

**MEDICAL TREATMENT:** I (We) do hereby authorize the SUNY College at Old Westbury medical and/or mental health counseling staff, upon consultation with a practicing physician and/or psychologist, to exercise for me (us) and on my (our) behalf all rights and duties with reference to consenting to appropriate medical or psychiatric care, medicines, and referrals, including care, transport, and treatment by any hospital or physician which they may deem necessary for the medical care of _____ (minor child's full name) on the advice of any treating physician, surgeon, dentist, psychologist, or other licensed health care professional.

**Information for Medical Treatment**

Physician's Name and Address: _____

_____

Physician's Phone Number: (_____) _____-_____

Medical Insurer/Health Plan: _____ Policy #: _____

Allergies to Medications: _____

Allergies (Other): _____

Please note **all** conditions for which the child is currently receiving treatment: _____

_____

Note any other significant medical information: _____

_____

SUNY OLD WESTBURY
OWN YOUR FUTURE

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I (We) further state that my (our) minor child is aware of his/her personal medical needs and hereby assures the college that s/he has consulted with medical staff as I (we) may have deemed necessary, with regard to his/her personal medical needs.

I (We) assure the college that we have carefully counseled my (our) daughter/son about the risks and responsibilities of attending the college as a minor child, and that s/he has our express permission to do so. This authorization is valid from _____ (date form is notarized) to _____ (date child turns 18).

In case of emergency, I (we) can be contacted at:

Cell Phone(s): (_____) _____-_____ (_____) _____-_____

Home Phone(s): (_____) _____-_____ (_____) _____-_____

Work/Alternate Phone(s): (_____) _____-_____ (_____) _____-_____

Email: _____

Signature: _____ Date: _____

Signature: _____ Date: _____
Signature of custodial parent(s) or legal guardian(s).

**<u>To be completed by a Notary Public</u>:**

Signed before me, _____ (Print name of witness), on this date _____ at _____ (name of location).

Signature: _____ (name of witness)

Address: _____

***NOTARY SEAL***