LE MOYNE
SPIRIT. INQUIRY. LEADERSHIP. JESUIT

Wellness Center
for Health and Counseling

1419 Salt Springs Road
Syracuse, NY 13214-1301
315-445-4440 (Health Office)

TO BE COMPLETED BY A PARENT/GUARDIAN

ONLY FOR STUDENTS WHO ARE UNDER

18 YEARS OLD AT TIME OF MATRICULATION.

CONSENT FOR TREATMENT OF A MINOR AND PERMISSION FOR HEALTH AND COUNSELING

Please complete this form and return it with the other required forms.

Student's Name (please print): _____

Date of Birth: _____

I hereby give permission to the health and counseling staff at Le Moyne College Wellness Center to treat my dependent son or daughter (print student name) _____ for all physical or emotional problems (including injuries) occurring while he or she is at college. Furthermore, in the event that I will not allow me to be reached, or that I cannot be reached, I hereby give permission to the College Wellness Center physicians and counselors to render care deemed necessary to routine care for my child, to include hospitalization, anesthesia, surgery and other indicated treatment.

Parent or Guardian Name (please print): _____

Signature (parent or guardian): _____ Date: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY

NAME: _____ **RELATIONSHIP:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME PHONE (WITH AREA CODE): _____

CELL/BUSINESS PHONE (WITH AREA CODE): _____