



# AUTHORIZATION FOR MEDICAL CARE AND TREATMENT OF A MINOR

**TO BE COMPLETED BY PARENT/GUARDIAN**

**Note: Without a signed authorization by parent/guardian, the Health Center cannot treat a student.**

**Student Name** \_\_\_\_\_ **DOB** \_\_\_\_\_  
Last Name First Name MM/DD/YYYY

“I, \_\_\_\_\_, being the parent or legal guardian of \_\_\_\_\_, hereby designate The Bryn Mawr College Health Center and/or any authorized member of its staff to examine and treat for all health and medical problems, injuries and emergency treatment that may occur.

I understand that for continuity of care, the Health Center would have access to emergency room records and hospital records at local hospitals, if my child were to need those services.

Bryn Mawr College Health Center will keep all medical information confidential as per the privacy policy which I have reviewed on the Health Services website.

I understand that this authorization is effective until the student reaches their 18th birthday.

**Parent/Guardian Signature** \_\_\_\_\_

Address \_\_\_\_\_

Phone number \_\_\_\_\_ Email \_\_\_\_\_

Date \_\_\_\_\_

**After the age of 18, the student must give the Health Center written authorization to speak to a parent/guardian.**