RUTGERS
UNIVERSITY | NEW BRUNSWICK

RUTGERS STUDENT HEALTH
PARENT/GUARDIAN AUTHORIZATION/CONSENT TO TREAT MINOR CHILD

Patient/Student Information

Name _____

Address _____

Local or Cell Phone _____

Date of Birth _____

RU ID# (if available) _____

New Jersey State Law requires that parental permission be obtained in advance for the diagnosis/treatment of a minor.

Parent/Guardian complete the following:

____ Yes, I give permission for the staff at Rutgers Student Health (medical and mental health professionals) to perform a diagnostic evaluation and provide treatment for my son/daughter while enrolled at Rutgers.

I certify by my signature that I understand the nature of this consent and voluntarily agree to its provisions. I understand I can withdraw my permission in writing at any time.

____ No, I do not give permission for the staff at Rutgers Student Health (medical and mental health professionals) to provide medical care for my son/daughter. For medical issues, please contact:

Name _____

Relationship to Student _____

Phone (Home, Work, Cell) _____

Parent/Guardian Name _____

Parent/Guardian Signature _____

Date _____

Please email, fax, or mail form to:

Hurtado Health Center
11 Bishop Place
New Brunswick, NJ 08901

Fax: 732-932-8255
Email: health@echo.rutgers.edu

For questions regarding this form, please contact: 848-932-7402