



Student Health Services
Health Professions Building
Suite 266

DALTON STATE COLLEGE
650 College Drive
Dalton, GA 30720
706.272.2532
Fax 706.272.2527

Dalton State College Health Center Consent for Treatment of Minor Students

Permission for Diagnostic and Treatment Procedures

I hereby consent for my minor child or ward under the age of 18 years of age to receive medical care to receive medical care from the health care providers at Dalton State College Student Health Services and their agents and consultants, including area hospitals. I authorize such treatment as x-rays or other diagnostic studies, as, in the judgement of the attending health care provider, may reasonably be necessary to preserve and protect the health of my minor child or ward. This consent shall remain in effect until revoked by the parent, until the minor becomes 18 and can provide consent, or until the student is no longer enrolled at Dalton State College. I understand that any medical treatment provided outside the student health center is not covered by the student health fee and is the responsibility of the student or responsible party.

*Students under the age of 18 must provide a consent for treatment of a minor signed by parent or legal guardian.

Student Name _____ **DOB** _____

Parent/Guardian Signature _____ **Date** _____

I authorize the staff at Dalton State College Student Health Services to discuss any information regarding the health of my minor child or ward with the following parents or legal guardians listed below:

Parent/Legal Guardian Name: _____

Parent/Legal Guardian Name: _____

Confidentiality and Notice of Privacy Practices Acknowledgement

Medical information contained in all health records is strictly confidential and may not be released without written permission.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and Family Educational Rights and Protection Act (FERPA), students have certain rights to privacy regarding their protected health care information. I have read and understand the Dalton State College Health Centers Notice of Privacy Policy.

Student Name _____ **DOB** _____

Parent/Guardian Signature _____ **Date** _____

Release of Medical Information

I authorize the release of any medical information to consulting medical providers, including those seen on a referral basis and emergency medical services as necessary to help ensure that my minor student receive appropriate services.

Student Name _____ **DOB** _____

Parent/Guardian Signature _____ **Date** _____