ITHACA COLLEGE
Hammond Health Center

Accredited by the ACCREDITATION ASSOCIATION for AMBULATORY HEALTH CARE, INC.

Please complete this form and return to: Health Certifications, Hammond Health Center, Ithaca College, 953 Danby Rd., Ithaca, N.Y. 14850 **OR fax to:** (607)274-1844

Consent for Treatment of a Minor

PERMISSION FOR MEDICAL CARE

To be completed only for students under 18 at time of matriculation:

Student's Name (please print):_____

Ithaca College ID Number: ____ ____ ____ - ____ ____ ____ - ____ ____ ____

I hereby give permission to the medical staff of Ithaca College's Hammond Health Center to examine and treat my son or daughter (print student name)_____, for all medical problems and injuries occurring while he or she is at school. Furthermore, in the event that time will not allow me to be reached, or that I cannot be reached, I hereby give permission for the College health center physicians to secure necessary consultative care for my child, to include hospitalization, anesthesia, surgery, and other indicated treatment.

Name (please print):_____

Signature: _____ Date:_____
(parent/guardian)

PERSON TO NOTIFY IN CASE OF EMERGENCY

_____
Name (last, first) Relationship

_____
Address

_____
City State Zip

_____
Home Telephone Cell/Business Telephone

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Ithaca College Student Health Service, 953 Danby Rd., Ithaca, NY 14850
Privacy Official: 607-274-3177

Please review our "Notice of Privacy Practices" which describes how medical information may be used and disclosed and how you can get access to this information.

Notice of Privacy Practices Receipt

I acknowledge that I was provided with the "Notice of Privacy Practices" of the medical practice named at the top of this page. Please complete this notice of privacy practices receipt and sign both the receipt and the consent below.

Print Name of Student: _____

Student's Ithaca College ID: _____

Student's Date of Birth: _____

Signature of Student: _____

Date: _____

Please check this box if you are under 18: ☐

For Personal Representative of the Student (if a minor):

Print Name of Personal Representative: _____

Describe Personal Representative
Relationship (parent, guardian, etc.): _____

Signature of Personal Representative: _____

Date: _____

Consent for Purposes of Treatment, Payment, or Health Care Operations

I consent to the use or disclosure of my protected health information by the Ithaca College student health services staff for the purpose of diagnosis or treatment, obtaining payment for health care services rendered, or in order to conduct health care operations.

I understand that I have the right to request a restriction or limitation on how and to whom my protected health information is used or disclosed for the above purposes. The Ithaca College Hammond Health Center is not required to agree to such a request, but if agreed upon, the center will comply unless the information is needed to provide me emergency treatment.

The "Notice of Privacy Practices" describes my rights as well as Ithaca College Hammond Health Center's rights and responsibilities with respect to my protected health information.

Signature of Student (or personal representative if a minor): _____

Name of Student: _____

Date: _____

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MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE FORM

New York State Public Health Law requires that all college and university students enrolled for at least six (6) semester hours or the equivalent per semester, or at least four (4) semester hours per quarter, complete and return the following form to Hammond Health Center, Ithaca College, 953 Danby Road, Ithaca, NY 14850.

Check only one box and sign below.

I have, or my child (parent complete if child is a minor, under age 18) has:

☐ had the meningococcal meningitis immunization within the past 5 years.
(*Note: The Advisory Committee on Immunization Practices recommends that all first-year college students up to age 21 years should have at least 1 dose of Meningococcal ACWY vaccine not more than 5 years before enrollment, preferably on or after their 16th birthday, and that young adults aged 16 through 23 years may choose to receive the Meningococcal B vaccine series. College students should discuss the Meningococcal B vaccine with a healthcare provider.)*

☐ read, or have had explained to me, the information regarding meningococcal meningitis disease. I (my child) will obtain immunization against meningococcal disease **within 30 days** from my private health care provider or at the Hammond Health Center.
(*Note: If you receive the meningitis vaccine from your private provider, please provide Hammond Health Center with a record of this vaccine. If you prefer to receive this vaccine from Hammond Health Center, please call 607-274-3177 to schedule an appointment.*)

☐ read, or had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I (my child) will **NOT** obtain immunization against meningococcal meningitis disease at this time.

Student's Signature: _____ Date: _____
(parent/guardian if student is a minor)

Print Student's Name: _____ Student's Date of Birth: _____

Student's E-Mail Address: _____ Student's ID#: _____

Student's Mailing Address: _____

_____

Students's Phone Number: _____