SOUTH DAKOTA STATE UNIVERSITY

Student Health Clinic and Counseling Services

Consent for Treatment of a Minor

South Dakota law requires unemancipated patients under age 18 to have parental/guardian consent before receiving medical care, except in emergencies and for medical diagnosis and treatment of sexually transmitted diseases. The purpose of this consent form is to allow Student Health Clinic and Counseling Services (SHCCS) to treat your minor child while they are a registered student at SDSU. Accordingly:

I authorize SDSU Student Health Clinic and Counseling Services permission to treat:

_____ _____ ____/____/____

Full Name of Minor Child | Student ID Number | Date of Birth

My signature below indicates that I am the legal parent or guardian of the above named minor child and that I am allowing my minor child to be treated at the Student Health Clinic and Counseling Services (SHCCS) while they are a registered student at SDSU. Services may include, but are not limited to, medical and mental health services including examinations, laboratory testing, immunizations, minor surgical procedures, prescriptions, and mental health counseling. Medical treatment does not include invasive procedures or other treatments which are unusual or carry a significant risk to the patient. I understand that no guarantees have been made as to the results of any of the above services. I grant permission to SDSU Student Health Clinic and Counseling Services, or designees to transfer my minor child to an accredited hospital or other care facility if deemed necessary by the SHCCS health provider. I authorize SDSU Student Health Clinic and Counseling Services to bill and provide my minor child's health information to the appropriate health insurance carrier or health plan to process claims arising from their care.

This consent will be in effect from this date until my minor child is 18 years of age or one year from the date of my signature below, whichever occurs sooner, unless cancelled earlier by me in writing.

My signature acknowledges that I have read and understand this consent and that any questions I have prior to signing this can be answered by calling SDSU Student Health Clinic and Counseling Services at 605-688-4157.

_____ _____ ____/____/_____

Signature of Parent/Guardian and Relationship | Print Name | Date

_____ _____

Phone Number | Alternate Emergency Contact Phone Number

-- For Clinic Use Only --

Phone Consent received from: _____ ____/____/_____

Name of Parent or Guardian | Date

Witness: _____

Witness: _____