



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 South Dakota State University (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 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.

Printed Name of Parent/Guardian	Relationship
---------------------------------	--------------

Signature of Parent/Guardian	Date
------------------------------	------

Phone Number	Alternate Emergency Contact Phone Number
--------------	--