NIAGARA UNIVERSITY

CONSENT FOR TREATMENT OF A MINOR
(Required for students under 18 years old)

NAME OF STUDENT	DATE OF BIRTH (MM/DD/YYYY)	COLLEGE ID #

I, _____, hearaeby authorize Niagara University's Health Services Provider, and whomever he/she may suitable designate, to administer necessary medical care of my child _____.

Signature of Parent/Guardian:_____

Printed Name:_____

Date:_____

** This signed form is valid for one year fom the date of the signature. It may be revoked at any time by written request form the parent/guardian.**