BARUCH COLLEGE
RESIDENCE LIFE

Continuum Health Partners

[ ] BARUCH COLLEGE
STUDENT HEALTH CENTER
138 East 26th Street, Street level, NY, NY 10010
Phone (646) 312-2040 Fax (646) 312-2041

[ ] YESHIVA UNIVERSITY
STUDENT HEALTH CENTER
Wilf Campus-500 West 186th Street**,** NY, NY 10033
Phone (646) 685-0391 Fax (646) 685-0395
Beren Campus- 50 East 34th Street, 2nd fl, NY, NY 10016
Phone (212) 340-7792 Fax (212) 340-7858

[ ] MARYMOUNT MANHATTAN COLLEGE
STUDENT HEALTH CENTER
231 East 55th Street, 1st fl, NY, NY 10022
Phone (212) 579-5870 Fax (212) 579-5879

[ ] Occupational Medicine/Employee Health at BIMC
317 East 17th St, 2nd floor, NY, NY 10003

CONSENT FOR TREATMENT OF A MINOR

Please print all information:

Student Name	Social Security #	Date of Birth
Address		Home Phone
City	State	Zip
☐ Male ☐ Female	Place of Birth	US Citizen? ☐ Yes ☐ No
Insurance Carrier		Policy or Group #

The relationship between a student and the College is confidential. Medical information will only be released when and if prescribed by law and/or at the written request of the student or guardian.

PARENTAL PERMISSION: The law requires that parental permission be obtained for treatment and for vaccinations (as recommended by The Centers for Disease Control and New York State Department of Health) for persons less than 18 years of age (minors). This consent form should be signed by parents so that such treatment/vaccination may be promptly carried out and unnecessary delays be avoided.

I give permission to the Student Health Center for vaccinations and treatment procedures as may be deemed medically necessary for my son/daughter named above.

(Print) Name of Parent/Guardian _____ Relationship: _____

Parent/Guardian Signature _____ Date: _____

Parent/Guardian contact information (phone# &/or email) _____