



Health Services

MINORS AND STUDENTS WITH GUARDIANS CONSENT FORM

Bethel University Health Services complies with state laws when providing health services to minors (persons under age 18) or student with guardian. Under the following circumstances a minor or student with guardian can independently consent to receive medical, dental, mental, or other health services:

- if the minor or student with guardian is emancipated, i.e., living away from parents or legal guardian and managing their own finances, regardless of income source (international minor students have emancipated status);
- if a minor or student with guardian is married or have given birth to a child; or
- if a minor or student with guardian requires services to determine the presence of or to treat pregnancy and conditions associated therewith, venereal disease, alcohol (including screening for) and other drug abuse.

Minors or student with guardian not meeting the above criteria require parental/guardian authorization for health services except when emergency care is required, i.e., the risk to life or health is of such a nature that treatment should be given without delay, and the requirement of consent would result in delay or denial of treatment.

Staff may inform a minor's parents or legal guardian of treatment provided or care needed where, in the professional's judgment, failure to inform the parents or guardian would seriously jeopardize a minor's health.

I authorize that in the event of an illness or injury, medical or hospital care be provided to _____.

I further authorize each of the following:

- A. I grant permission to the Health Services provider to employ such diagnostic procedures and medical treatment or mental health counseling as deemed necessary.
- B. I authorize Health Services to release medical records information to the appropriate health insurance carrier in order to process claims.
- C. I understand that I am financially responsible for charges not covered or paid by insurance and hereby guarantee full payment. I agree that services will be paid as billed to the student account.

A REPRODUCTION OF THIS DOCUMENT IS AS VALID AS THE ORIGINAL.

Name of Parent or Legal Guardian _____

Address _____

City _____ State _____ ZIP _____

Telephone Number _____

Signature of Parent or Guardian _____ Date: _____

For Emancipated Minor:

Circumstances allow me to consent to my own treatment and health services.

Signature of Emancipated Minor _____ Date: _____

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Health Service Use Only:

Witnesses _____ Date: _____

_____ Date: _____