1 EOP STUDENT PARENTAL CONSENT FORM

Students attending Binghamton University are generally considered independent adults, and parental consent for medical care for those under 18 years of age are not routinely required. However, if medical concerns arise during summer, this information is referenced by medical professionals responding to emergencies. Should any of this information change, please notify the EOP Office as soon as possible.

"I, ___________________________________ pursuant to the authority vested in me as Parent/Guardian of:

Student name: ____

B-number: ____

Student Date of Birth: ___________________________________ (month/day/year)

do hereby authorize the medical staff upon consultation with a practicing physician or surgeon to exercise for me and on my behalf, all rights and duties with reference to consenting to appropriate medical, psychiatric, and surgical treatment, anesthetics, medicines and hospitalization, including care and treatment deemed necessary for the emergency care of my child during the 2024 Binghamton Enrichment Program, July 1st – August 2nd , 2024."

CONSENT OF PARENT/GUARDIAN FOR MEDICAL / EMERGENCY TREATMENT

Parent/Guardian Signature ____

Date _____________________________________

EMERGENCY CONTACT

First Name: ________________________________ Last Name: _____________________________________

Relationship to student: ____

Best number to reach contact: ____________________________ Alternate #_____________________________

STUDENT'S HEALTH INSURANCE INFORMATION

Company: ______________________________________ Policy #: ______________________________________

____

2 EOP EMERGENCY CONTACT AND AUTHORIZATION FOR RELEASE FORM

Student
Last Name ___________________________________ First ___________________________________ MI____

Date of Birth: _______/_______/_________ (Month/Day/Year)

Please list any **Special Medical Needs**, **Religious Observations**, or **Dietary Restrictions** we should be aware of:

____

____

If applicable, please list **Prescribed Medications**:

____

____

____

Please list any **allergies to food or medicine or other**:

____

STUDENT CONSENT TO RELEASE INFORMATION

Should the need for medical attention arise, I, ____,
(Student Name)
hereby authorize release of any health information pertinent to my well-being and provision of care and treatment to the appropriate EOP professional staff. Consent regarding services received is for the purpose of ensuring adequate treatment and follow-up care. Health care professionals include, but are not limited to, providers at local hospitals/walk-in clinics, Decker Student Health Services Center, and the University Counseling Center, as well as others with pertinent information regarding my well-being.

*I understand that authorizing the aforementioned release is voluntary and not a condition for treatment, nor admission to Binghamton University. I have the right to revoke this authorization at any time, in writing, to the Educational Opportunity Program Office at Binghamton University.

Student Signature____ Date __________________________

Parent/Guardian Signature ____ Date ___________________
(If student is under 18 yrs of age)