PARENTAL/GUARDIAN CONSENT TO TREATMENT OF A MINOR (If student will be under 18 at arrival on campus)

STUDENT NAME: _________________________________BIRTH DATE: ________________

Towson ID# _____________

I hereby authorize the professional staff of the Dowell Health Center of Towson University to carry out or to request such diagnostic and therapeutic measures for my son/daughter as may be considered necessary or advisable by the treating provider. I also authorize the release to other physicians who may be treating my son/daughter, relevant medical information as to treatment provided my son/daughter through the university's Student Health Service. I understand I will be notified as soon as possible in the event of life-threatening illness or injury.

Signature of Parent or Legal Guardian ___________________________________

Date____________________

Please return this form to:

Dowell Health Center
8000 York Road
Towson, Maryland 21252-0001