



Parent/Guardian Permissions for Student Under Age 18*

Please print and sign in ink. We are not authorized to accept electronic signatures or signature images.

1. INFORMATION (please print)

Name of student (first, middle, last) _____

Name of parent/guardian _____

Today's date (mm-dd-yyyy) _____ Student date of birth (mm-dd-yyyy) _____

2. ACKNOWLEDGMENT OF PRIVACY PRACTICES

Please review our Notice of Privacy Practices. It describes our policy and the ways in which we use and protect your student's personal health information: health.cornell.edu/about/confidentiality-patient-rights (pdf)

- I acknowledge that I have been made aware of the Notice of Privacy Practices of Cornell Health.

 Signature of parent or guardian _____

3. PERMISSION TO TREAT, AND CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Cornell Health provides and coordinates health care for students when they are in the Ithaca area. If your student requires treatment at Cayuga Medical Center, another hospital or urgent care center, or a specialist, the community provider and Cornell Health will share relevant health information as needed for continuity of care. In the event of a major health problem, whenever possible, specific permission will be obtained from you.

- I give my permission for my daughter/son/ward to receive health care from Cornell Health, Five Star Urgent Care, Cayuga Medical Center (including Convenient Care), appropriate specialists, and ambulance services in the event of an injury, illness, or other treatment necessary to assure the continued health of the student.
- I consent to have Cornell Health use and disclose my student's protected health information for payment, treatment, and health care operations purposes. Protected health information means health, billing, and demographic information about or collected from your student, and created or received by Cornell Health.
- I understand that I will be responsible for all charges for health services provided by Cornell Health and by off-campus providers.
- In the event Cornell Health participates with my student's health insurance, I authorize the payment of benefits to Cornell Health.

 Signature of parent or guardian _____

4. CONSENT FOR IMMUNIZATIONS (not required for students taking fewer than 6 credits)

Students taking 6 or more credits who have not had all the required immunizations must receive them from Cornell Health soon after arriving on campus. (See health.cornell.edu/requirements.) We need your signed permission to administer these. We will not re-vaccinate students who have submitted proof of prior vaccination. Please **check the box(es)** for any of the *recommended* immunizations you would like your student to receive.

I give my consent for Cornell Health to administer to my student:

- **Any required immunizations that may be necessary for full compliance.**

...and the following immunizations recommended for by the U.S. Centers for Disease Control and Prevention (CDC) and the American College Health Association:

☐ Hepatitis B ☐ Meningococcal (quadrivalent)

 Signature of parent or guardian _____

Because you may not know which required immunizations will be needed, it is recommended that you review the Vaccine Immunization Statements (VIS) for the following: TDaP; Measles, Mumps, Rubella (MMR), and Varicella (Chicken Pox). These are available online at health.cornell.edu/vaccine-info.

The VIS for recommended immunizations also are linked here.

For more information about required and recommended immunizations, please visit:
health.cornell.edu/services/medical-care/immunizations

*** These authorizations are required and will be in force until your student reaches his/her 18th birthday.**

INSTRUCTIONS

1. Complete in full:

- check all appropriate boxes, and
- provide all signatures

2. Return ONE COPY only:

➤ **UPLOAD through myCornell Health:**

Go to mycornellhealth.health.cornell.edu

- Log in with Cornell net ID, password, and date of birth.
- From Home Screen, click on "Messages."
- Then "New message;" then "Send message or attachment to Health Records."

➤ **or FAX:** 607.255.0269

➤ **or MAIL:** Cornell Health, Attn: Requirements Office 110 Ho Plaza Ithaca, NY 14853-3101