RAMAPO COLLEGE OF NEW JERSEY

Center for Health & Counseling Services

Health Services
505 Ramapo Valley Road, Mahwah, NJ 07430-1680
Phone (201) 684-7536 Fax (201) 684-7534
www.ramapo.edu

AUTHORIZATION TO TREAT A MINOR

This consent shall remain effective until _____, 20_____ (date minor turns 18 y.o.)

I (we) the undersigned parent, parents or legal guardian of _____, a minor, do hereby authorize and consent to any examination, medical or surgical diagnosis and treatment rendered by any member of the Ramapo College of New Jersey, Health Services medical staff. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power to render care which the aforementioned medical provider in the exercise of his / her best judgment may deem advisable. It is understood that every effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

List any
restrictions:_____

_____

_____

Signature of Father, Mother or Legal Guardian:
_____Date:_____

Address:_____

City:_____ State:_____ Zip:_____

Telephone Numbers Where Parents or Guardian May Be Reached

Father:_____ Home:_____
Work:_____

Mother:_____ Home:_____
Work:_____

Guardian:_____ Home:_____
Work:_____

Family Physician:_____

Address:_____

City:_____ State:_____ Zip:_____