

**RUTGERS STUDENT HEALTH  
PARENT/GUARDIAN AUTHORIZATION/CONSENT  
TO TREAT MINOR CHILD**

**Patient/Student Information**

Name \_\_\_\_\_

Address \_\_\_\_\_

Local or Cell Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_

RU ID# (if available) \_\_\_\_\_

*New Jersey State Law requires that parental permission be obtained in advance for the diagnosis/treatment of a minor.*

**Parent/Guardian complete the following:**

\_\_\_ Yes, I give permission for the staff at Rutgers Student Health (medical and mental health professionals) to perform a diagnostic evaluation and provide treatment for my son/daughter while enrolled at Rutgers.

I certify by my signature that I understand the nature of this consent and voluntarily agree to its provisions. I understand I can withdraw my permission in writing at any time.

\_\_\_ No, I do not give permission for the staff at Rutgers Student Health (medical and mental health professionals) to provide medical care for my son/daughter. For medical issues, please contact:

Name \_\_\_\_\_

Relationship to Student \_\_\_\_\_

Phone (Home, Work, Cell) \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Please email, fax, or mail form to:

Hurtado Health Center  
11 Bishop Place  
New Brunswick, NJ 08901

Fax: 732-932-8255  
Email: [health@echo.rutgers.edu](mailto:health@echo.rutgers.edu)

For questions regarding this form, please contact: 848-932-7402