BARNARD
Primary Care Health Service

Accredited by the
ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE, INC.

Under 18: REQUIRED PRIOR TO ARRIVAL AT BARNARD

TO BE COMPLETED & SIGNED BY YOUR PARENT/GUARDIAN

MINORS CONSENT FORM

Consent for Treatment of Minors:
If your child is age 17 or younger this form must be completed.

Please print legibly in blue or black ink

Student Name: _____
First Middle Last

Student Date of Birth: _____/_____/_____
M D Y

I, _____hereby give permission to the
(Print Name of Parent/Guardian)

clinicians at the Barnard College Primary Care Health Service to provide medical care for

_____.
(Print Student's Legal Name)

I understand that clinicians are compelled by the laws of the State of New York to maintain my child's confidentiality with regard to all sexuality-related health needs.

Signed: _____ Date: _____
(Parent/Guardian's Signature) ***(MM/DD/YY)***