Valdosta State University
Student Health Center

200 Georgia Avenue
Valdosta, GA 31698

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www.valdosta.edu/health

HEALTH SERVICES TO MINORS CONSENT FORM

Valdosta State University Student Health Center complies with the laws of the State of Georgia when providing health services to minors (persons under age 18). Under the following circumstances a minor can independently consent to receive medical, mental, or other health services:

- if the minor is emancipated, i.e., living away from parents or legal guardian and managing their own finances, regardless of income source (international minor students have emancipated status);
- if a minor is married or have given birth to a child; or
- if a minor requires services to determine the presence of pregnancy and conditions associated therewith, venereal disease.

Minors not meeting the above criteria require parental/guardian authorization for health services except when emergency care is required, i.e., the risk to life or health is of such a nature that treatment should be given without delay, and the requirement of consent would result in delay or denial of treatment.

Valdosta State University Student Health Center staff may inform a minor's parents or legal guardian of treatment provided or care needed where, in the professional's judgment, failure to inform the parents or guardian would seriously jeopardize a minor's health.

I authorize that in the event of an illness or injury, medical or hospital care be provided to_____.

I further authorize each of the following:

A. I grant permission to the Valdosta State University Student Health Center health care provider to employ such diagnostic procedures and medical treatment or mental health counseling as deemed necessary.

B. I authorize the Valdosta State University Student Health Center to release medical records information to the appropriate health insurance carrier in order to process claims.

C. I understand that I am financially responsible for charges not covered or paid by student fees or insurance and hereby guarantee full payment to Valdosta State University Student Health Center. I agree that services will be paid for at the time of service unless I am covered by Student Service Fees or a health plan that includes Valdosta State University Student Health Center as a participating provider.

A REPRODUCTION OF THIS DOCUMENT IS AS VALID AS THE ORIGINAL.

Name of Parent or Legal Guardian:_____

Address:_____

City:_____ State:_____ Zip:_____

Telephone Number:_____

Signature of Parent or Guardian:_____ Date:_____

Notary:_____ Date:_____

For Emancipated Minor:
Circumstances allow me to consent to my own treatment and health services.

Signature of Emancipated Minor:_____ Date:_____

VSU Student Health Services Use Only:

Witnesses:_____ Date:_____

_____ Date:_____

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