Wesleyan University
Davison Health Center
327 High Street, Middletown, CT 06459
860-685-2470 phone 860-685-2471 fax
healthforms@wesleyan.edu

Student Health Consent for Treatment Form

Student Name: _____ **Student ID:** _____
Last First

I hereby grant permission for the Wesleyan University Student Health Services staff to provide appropriate medical treatment including coordination of care among clinicians, medications for treatment of illness/injury and to arrange for any emergency medical care if circumstances at that time make it impossible for me to make such decisions.

I understand that Student Health Services may disclose information from my medical records to appropriate University staff and/or family and/or Emergency contacts in the case of a health or safety situation as deemed necessary by Student Health Services staff.

I certify that to the best of my knowledge that the information I am submitting to the Student Health Portal is complete and correct. I also acknowledge that I have read the "Notice of Privacy Practice Form".

This authorization will remain in effect as long as I am a student at the Wesleyan University.

Please review HIPAA notification documents.

Signature(s) below indicates understanding of an agreement with the above information.

Student Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____
(Required if student is under 18 years of age)

Submit completed form by scanning and uploading to the Student Health Portal – wesleyan.medicatconnect.com.