SPECIAL AUTHORIZATION FOR MINORS

Consents and acknowledgements

I hereby authorize the clinical staff at Boston University Student Health Services to examine and treat me during my enrollment at Boston University. _____
Initial

I understand that there is no charge to see a provider at Boston University Student Health Services. However, I understand that I am responsible for miscellaneous charges including, but not limited to, lab tests, allergy injections, immunizations, and some supplies. I understand that I am responsible for all health care charges outside of Student Health Services except that which is covered by my health insurance. _____
Initial

I understand that some costs outside of Student Health Services may not be covered by my medical insurance.

_____
Initial

I understand that Student Health Services is a unit inclusive of medical, mental health, nutrition, sports medicine, and alcohol and other drug services. I understand that the providers within this organization may discuss my care within the unit to allow for effective care delivery and care management. _____
Initial

I understand that some services provided are limited by staff and space availability. While we may endeavor to serve all students eligible for care, there may be circumstances when referral to outside providers in the community is necessary.

_____
Initial

The information on this form is for the use of Student Health Services and will not be released to a third party without your consent, except as necessary to fulfill the responsibilities of Student Health Services or as required by law.

_____
Initial

_____
Student Name (Print) Student Signature Date

_____
(Must be signed by a parent or guardian if student is under 18 years of age)