

RISD Health Services

20 Washington Place
Providence, RI 02903
(401) 454-6625 (phone)
(401) 454-6628 (fax)



CONSENT FOR TREATMENT OF MINOR STUDENT (under 18)

As parent or guardian of _____ [the minor student], the undersigned hereby authorizes and consents to the performance of any medical care that the minor student may require including, but not limited to, examinations, treatment, immunizations, and/or referrals to qualified health providers as deemed advisable by the medical personnel of the Rhode Island School of Design ("RISD") Health Services.

This consent is conditioned on the understanding that in the event of a serious illness or the need for hospitalization and/or operative and surgical procedures, the college will use all reasonable efforts to contact me. Failure of such efforts, however, should not prevent the college from providing such treatment and care as may be necessary for the health, safety, and protection of _____ [the minor student].

I understand that to provide the best possible care for students, medical personnel of RISD Health Services may share information, when appropriate, with professionals within RISD Counseling and Psychological Services for the purposes of diagnosis and treatment planning. I acknowledge that RISD must abide by all applicable Rhode Island state laws, federal laws, and the individual policies of area hospitals with regard to consent to medical treatment of a minor. I understand that in the event of a medical emergency I may be contacted directly by hospital staff as necessary for the treatment or release of _____ [the minor student]. In consideration thereof, I hereby release and agree to indemnify RISD and its staff of any and all liability, claims, and causes of actions arising out of or in any way connected to the use of aforementioned medical services.

Full Legal Name of Minor Student: _____

Signature of Parent or Guardian: _____ Date: _____

Physical signature required