PARENTA NSENT FORM Return by mail, fax or email:

Salisbury University Student Health Services, Holloway Hall Room 180, 1101 Camden Avenue, Salisbury, MD 21801

FAX: 410-548-4101 • EMAIL: studenthealth@salisbury.edu

Name: (Last)______________________________________ (First) ______________________________ (MI) ____________

SU Identification Number: ____ Date of Birth: ______________________________

Permission to Treat a Minor

A parent or guard an o an /tudent under t e age o u/t pro/ de on/ent read ng and / gn ng t e /tate ent e o

ere grant per // on to tudent ea t er/ e/ to render ed a are to dependent
under/ tand t at a nor o/er t e age o a

Printed Name of Parent/Guardian

Signature of Parent/Guardian

Relationship to Student

Date of Consent

Salisbury UNIVERSITY