Tufts University
Tufts Summer Study
Dowling Hall
419 Boston Avenue
Medford, MA 02155
617-627-3454

Health Consent Form

Name of Student _____

Student Date of Birth _____

This form is required in order for staff clinicians at the Tufts University Health Service, or any other medical facility, to render medical services while you attend Tufts.

Student Consent (If student is older than 18 years of age)

I understand that the Tufts University Health Service (TUHS) and the Tufts University Counseling and Mental Health Service (CMHS), respect and to the maximum extent permitted by law, will maintain the confidentiality of any treatment information and services provided to me.

In the event of an emergency such as a serious illness or hospitalization if, in the professional judgment of the TUHS Medical Director or the Director of CMHS or their authorized representatives, it is reasonably necessary for my safety or the safety of others, I understand that the TUHS or the CMHS may take reasonable precautions to protect me and such others, and may, if necessary, disclose information about me to the Dean of Student Affairs Office or their designees.

The Dean of Student Affairs, the TUHS Medical Director, or the Director of CMHS (or their respective representatives) may, in their professional judgment, notify parents, guardians, or immediate family of information necessary to protect me or specifically identified individuals at risk of harm.

In addition, I understand that the medical staff and mental health staff are part of one organization and will communicate with one another when appropriate to ensure continuity and quality of care.

I consent to treatment should I request psychological assistance on an emergency basis (e.g., use of afterhours call support) and understand that a record of such request will be kept in my health record.

By signing below, I acknowledge that I have read, understand and accept the terms of this Consent.

Student Signature _____ Today's Date _____

Parent/Guardian Consent (If student is 18 years of age or younger)

I understand that the Tufts University Health Service (TUHS) and the Tufts University Counseling and Mental Health Service (CMHS), respect and to the maximum extent permitted by law, will maintain the confidentiality of any treatment information and services provided to my son/daughter/ward who is under the age of 18.

Name of Student _____

I hereby grant permission to the TUHS Medical Director and the Director of CMHS to furnish routine medical care as my son/daughter/ward may require, including examinations, treatment, immunizations and treatment for minor injuries. I understand that in the event of an emergency, such as a serious illness, injury or hospitalization, the TUHS Medical Director or CMHS Director, or their authorized representatives, will use all reasonable methods to contact me. Failure to contact me will not prevent them from providing such emergency treatment as may be necessary under the circumstances.

If, in the professional judgment of the TUHS Medical Director or the Director of CMHS, or their authorized representatives, it is reasonably necessary for my son/daughter/ward's safety or the safety of others, I understand that TUHS or the CMHS may take reasonable precautions to protect my son/daughter/ward or such others and may, if necessary, disclose information about my son/daughter/ward to the Dean of Student Affairs Office or their designees.

In addition, I understand that the TUHS medical staff and CMHS staff are part of one organization and will communicate with one another when appropriate to ensure continuity and quality of care.

I further consent to my son/daughter/ward's treatment should he or she request psychological assistance on an emergency basis (e.g., use of afterhours call support) and understand that a record of such request will be kept in his or her health record.

By signing below, I acknowledge that I have read, understand and accept the terms of this Consent.

Parent/Guardian Signature _____ Today's Date _____

Relationship to Student _____