

## Medical Consent

### 2024 SUNY Oneonta Migrant Leadership Academy

I, \_\_\_\_\_, am the \_\_\_\_\_ (father, mother or legal guardian) of \_\_\_\_\_, who will attend the SUNY Oneonta Migrant Leadership Academy (SOMLA).

I hereby give my consent, in the event that all reasonable attempts to contact me at \_\_\_\_\_ (telephone number[s]) have been unsuccessful, for the administration of any treatment deemed necessary by the SUNY Oneonta Health Center or A.O. Fox Memorial Hospital or in the event that said staff is not available, by another licensed physician or dentist and for the transfer of my child to any hospital reasonably accessible if necessary.

I hereby authorize the medical staff at SUNY Oneonta Migrant Leadership Academy (SOMLA) or A.O. Fox Memorial Hospital to exercise for me and on my behalf, all my rights and duties with reference to consenting to appropriate medical, psychiatric, and surgical treatment, anesthetics, medicines and hospitalization, including care and treatment by the Student Health Services and A.O. Fox Memorial Hospital or staff surgeon, physician or radiologist which they may deem necessary for emergency care of my son/daughter/legal guardian.

Intending to be legally bound hereby, I execute this consent:

\_\_\_\_\_

Signature of Parent/Guardian

\_\_\_\_\_

Date

STUDENT INJURY & SICKNESS INSURANCE IS NOW MANDATORY. Please provide insurance information.

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The above named student is covered by insurance:

Name of Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Type of Coverage (e.g. major medical, hospitalization, etc.):

\_\_\_\_\_

Policy or Account Number: \_\_\_\_\_