

## Consent to Medical and/or Surgical Procedure

**\*Important:** Must be signed by ALL students and by a parent/legal guardian if student is under 18 years of age. \*

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I/We hereby authorize the professional staff of the Homewood Student Health and Wellness Center of The Johns Hopkins University and /or any one of the Deans and/or the Director or official coaches of the Department of Athletics and Recreation of said University, in the event I/we shall not be readily available in connection with the need for the consent hereinafter referred to, to consent to, and authorize, in my/our behalf, medical treatment and/or the performing of any operative and surgical procedure and under any anesthetic, either local or general, for myself/our son/daughter, (Name of student) \_\_\_\_\_ while a student at said University, as may be considered necessary or advisable by the physician performing such treatment or surgery, and/or to release to other physicians who may be treating me/our son/daughter, relevant medical information as to treatment accorded me/him/her through the University's Student Health and Wellness Center.

The laws of Maryland require that surgical and medical treatment of minors (individuals less than 18 years of age) be at the request of and with the approval of their parents (and spouse of a married minor). The right to request and approve may be delegated to officials of the University. It is our policy to notify parents as soon as possible in the event of major illness or injury. We find it impractical to notify for every minor illness or injury requiring treatment. It will help us to protect the health of your son or daughter if you will delegate to us discretion in these matters.

Requests are received from hospitals, other physicians, other universities, and insurance companies for information about conditions treated by us. Parents of minors (and spouse of a married minor) must approve the release of such information and may delegate this discretion to physicians of the Student Health and Wellness Center. It is our policy to disclose medical information at the request of the student in the belief that it will be used for ordinary medical and insurance purposes.

**X Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**X Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

(if under 18 years of age, parent signature is required)