

CONSENT FOR RELEASE OF MEDICAL INFORMATION FOR STUDENTS
WITH SPECIAL HEALTH NEEDS

I, _____, give the Siena Health Service permission to release my name, medical condition and pertinent medical information to Siena College Security and the Dean of Student Affairs in order to facilitate appropriate emergency care if the situation should arise.

Signature of Patient

Signature of Parent if Patient is under age 18

Date

Witness

Please list the information you would like to release:

Name: _____

Medical Condition(s): _____
(include diagnoses like diabetes, asthma, seizures, severe allergies)

Pertinent Medical Information: _____

(include medications such as epi-pen, insulin, asthma inhalers and other special health needs) It is strongly recommended that you make your roommates and RA aware of any special health conditions.

Siena College admits students of any race, religion, color, sex, age, national and ethnic origin, disability status, marital status, veteran status and sexual orientation to all the rights, privileges, programs, and activities generally accorded or made available to students at the school. It does not discriminate on the basis of race, religion, color, sex age, national or ethnic origin, disability, marital status, veteran status sexual orientation, or any status or condition protected by applicable federal or state statutes in administration of its education policies, admissions policies, scholarship and loan programs, and athletic and other school administered programs.