

**Wheaton College  
Student Health Services  
Emergency Contact Information and Treatment of Minors**

Please complete and email this Minor Consent Form to [student.health.services@wheaton.edu](mailto:student.health.services@wheaton.edu). You may also upload it with the rest of the new student medical forms to your student's Northwestern Medicine MyChart account.

**Emergency Contact Number for Minor's Parent or Guardian:**

All active Wheaton College students that are minors (less than 18 years of age) must have a parent or guardian that can be contacted in case of a medical emergency or if medical treatment is needed. The parent or guardian must be a responsible adult preferably greater than 21 years old and present in the United States of America.

The following student \_\_\_\_\_,  
(hereafter "Minor") DOB: \_\_\_\_\_, ID# \_\_\_\_\_, is a minor.

The following person(s) are the named parent or guardian:

\_\_\_\_\_  
Address: \_\_\_\_\_  
City/State: \_\_\_\_\_  
Cell Phone Number: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_

**Authorization and Consent of Parent(s) or Legal Guardian(s) For Emergency Treatment:**

I \_\_\_\_\_ (hereafter "Designated Adult") do hereby state that I have legal custody of the aforementioned Minor. The Designated Adult grants authorization and consent for the following Wheaton College departments (**check all that apply**):  **Student Health Services**  **Athletics**  **HoneyRock** to administer general first aid treatment for any minor injuries or illnesses experienced by the Minor and then will inform the Designated Adult post procedure of the incident and treatment. If the injury or illness is life threatening or in need of emergency treatment, the Designated Adult authorizes the above departments to summon any and all professional emergency personnel to attend, transport, and treat the minor. This consent may include any X-ray, anesthetic, blood transfusion, medication, or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the State in which such treatment is to occur. The Designated Adult agrees to assume financial responsibility for all expenses of such care.

This authorization is effective through: \_\_\_\_\_. Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

Parent / Legal Guardian Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_

Reviewed 4/2026

**Wheaton College  
Student Health Services  
Informed Consent Regarding Medical Services for Minors**

I, the Designated Adult, realize that the Minor must be an active enrolled student at Wheaton College to be eligible to receive free services directed by Student Health Services, HoneyRock, and/or Athletics. Initial: \_\_\_\_\_

I, the Designated Adult, understand that available services are limited to the scope and hours of operation of Wheaton College Student Health Services/ HoneyRock, and/or Athletics. Initial: \_\_\_\_\_

I, the Designated Adult understand that the Minor may be referred to an off-campus counselor and/or medical provider by way of referral by a Registered Nurse at Wheaton College Student Health Services, HoneyRock, Athletic Department, or due to the limits of scope of hours of operation of the Student Health Services, or at the Minor’s request. Initial: \_\_\_\_\_

I, the Designated Adult, understand that the Minor may be assessed at Student Health Services/ HoneyRock by a Registered Nurse, Athletic Trainer or behavioral health specialist and provided instructions for self-care without notifying the parent/guardian. Initial: \_\_\_\_\_

I, the Designated Adult, understand that the Minor may be seen by a Student Health Services, HoneyRock, Athletic physician or nurse practitioner and given a diagnosis. However, treatment will not be provided until the physician/nurse practitioner discusses the case with the parent/guardian. Initial: \_\_\_\_\_

I, the Designated Adult, understand that in the State of IL and WI, certain mental health therapies may be provided to the Minor without disclosure to the parent/guardian. Initial: \_\_\_\_\_

I, the Designated Adult, authorize Student Health Services/HoneyRock/Athletics to provide the following medications/procedures to the Minor after assessment by a licensed professional without prior notification from the Designated Adult if not otherwise contraindicated:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Tylenol/Acetaminophen                  | <input type="checkbox"/> Ibuprofen                  | <input type="checkbox"/> Rapid Mono Test     |
| <input type="checkbox"/> Dextromethorphan                       | <input type="checkbox"/> Sudafed/Other decongestant | <input type="checkbox"/> Rapid Strep Test    |
| <input type="checkbox"/> Guaifenesin                            | <input type="checkbox"/> Pepto-Bismol               | <input type="checkbox"/> Rapid Flu Test      |
| <input type="checkbox"/> Benadryl or other<br>OTC antihistamine | <input type="checkbox"/> Hydrocortisone cream       | <input type="checkbox"/> Preventive physical |
|   | <input type="checkbox"/> COVID Test                 | <input type="checkbox"/> HCG test            |

**Parent/Guardian’s Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Parent/Guardian’s Name:** \_\_\_\_\_

Student Health Services Staff: Complete this section when verbal consent is obtained.	
Verbal Consent Received on _____ by _____ as witnessed by:	
Date	Parent/Guardian
_____ and _____	
Staff Signature	Staff Signature