PLEASE BRING IN YOUR MMUNIZATION RECORDS

CSUDH
CALIFORNIA STATE UNIVERSITY DOMINGUEZ HILLS

Student Health Center
(310) 243-3629

CONSENT FOR TREATMENT

Student I.D.#_____
Sex: ❒ M ❒ F ❒ X

Date of Birth:_____/_____/_____

Do you have a preferred name? If so, please specify.
_____

Ethnicity: (If bi-racial or multi-racial, check all that apply) □ African American □ Asian, Pacific Islander □ Caucasian, White □ Chicano, Latino, Hispanic □ Native American Indian □ Other:_____

Name_____
Last First M.I. Maiden

Mailing Address_____
(Number & Street) (City & State) (Zip)

Current Telephone Number ( )_____ ( )_____ ( )_____
Home Cell Work

IN CASE OF EMERGENCY NOTIFY: ❒ Parent ☐ Guardian ☐ Other_____

Name_____ **Phone#** ( )_____

Address_____

AUTHORIZATION AND CONSENT FOR TREATMENT

I hereby give consent to the clinical staff of the Student Health Center (SHC) at California State University, Dominguez Hills, for medical examinations, medical or surgical treatment of illness and/or injuries, diagnostic procedures (including x-ray and laboratory tests), administration of drugs, or for any other care when any or all of the foregoing is deemed necessary by, and is to be rendered under the general supervision of, a qualified California licensed health care provider. My treatment will be confidential and my records will not be released to anyone without my permission, except by subpoena or other legally required reporting. SHC does not use e-mail to initiate therapeutic conversations, as e-mail is not considered confidential. If necessary, I agree to be contacted regarding medical issues at the contact information above.

I also understand that the SHC is limited in its ability to provide continuous and/or comprehensive health care as the SHC is closed in the evenings, on weekends, and during holidays, and the provision of care is based on enrollment status. I understand that an individual may be referred to off campus medical providers if the individual is not currently enrolled at CSUDH, if the medical services needed are beyond the scope, expertise, or hours of operation of the SHC, or at the individual's request. I realize that individuals/families must make their own arrangements to pay for health care provided by an off-campus entity.

NOTE: Student-Athletes: I further grant permission to transmit to the CSUDH Athletics Department information about my health which might affect my participation in team sports.

❒ I authorize text reminders to be sent to ( )_____ Carrier: _____
(i.e: ATT, Verizon, Sprint)
❒ I **DO NOT** authorize text reminders.

_____ _____
(Student Signature) **(Date)**

_____ _____
(Parent's or Guardian's Signature if Student under Age 18) **(Date)**

Rev. 2/05/09, 8/2016, 6/2017

Please turn page for Privacy Notification*

PRIVACY NOTIFICATION

The State California Information Practices Act of 1977 requires the University to provide the following information to individuals who are asked to supply information about themselves:

The principal purpose for requesting the information on this form is to aid the Provider who will be meeting with you. University policy authorizes maintenance of this information, and it is confidential, in keeping with University policies applicable to the Student Health Center.

Individuals have the right to request access to their own records in accordance with the University Policy.

Further information on CSUDH Student Health Center's Policy on Privacy and Confidentiality of Medical Records can be found at: https://www.csudh.edu/shs/student-health-services/general-info/

The official responsible for maintaining the information on this form and for authorized access of your records is:

Irina Gaal, MD
Director, Student Health Services
SHC A-129

PLEASE COMPLETE INFORMATION ON THE OTHER SIDE