(Circle) **Student or Employee/agent**

CAL MARITIME

Student Health Center

PATIENT INFORMATION

Name_____
Last First Middle

Address_____
Street City State Zip

Birth date ___ ___/___ ___/___ ___ ___ ___ Age _____ ❑ Female ❑ Male ❑ _____

E-mail _____ Cell Ph # (_____) _____

EMERGENCY CONTACT INFORMATION

Name_____
Last First Middle

Relationship_____

Work (____) _____ Home (____) _____

E-mail _____ Cell Ph # (_____) _____

CONSENT FOR TREATMENT FOR COVID-19 Testing

I hereby give consent to the clinical staff of the American Medical Response to administer a viral (PCR) test to me for COVID-19. I hereby give consent to the Student Health Center at California State University, Maritime Academy for communication and consultation with me of the results of this test.

I hereby give consent to the Student Health Center for medical examinations, preventive care, 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 confidential medical record will not be released for non-treatment related purposes without my written permission, except by subpoena or other legally required reporting. I also understand that the Student Health Center is limited in its ability to provide continuous and/or comprehensive health care as the Student Health Center is closed in the evenings, on weekends, and during holidays, and the provision of care is based on enrollment or employment status. General Medical Records are retained for 10 years after the most recent activity or visit date. Occupational medical records are maintained for 30 years after termination of employment (except for those employed less than a year).

I understand that I am free to withdraw my consent for treatment at any time, and that this consent will remain in effect until I give notice that I choose to terminate it.

Patient signature:_____**Date:**_____

A CAMPUS OF THE CALIFORNIA STATE UNIVERSITY

Address
Cal Maritime Student Health Center
200 Maritime Academy Drive
Vallejo, CA 94590-8181

Phone
707-654-1170
www.csum.edu/web/health-services

Fax
707-654-1171