Student Health Record

LAST NAME FIRST MIDDLE	GENDER	DATE OF BIRTH *(MM/DD/YYYY)*

LOCAL	STUDENT CONTACT NUMBERS
Address: City/ State/ Zip:	Local Home Phone: ( ) Mobile Phone: ( ) Permanent Home Phone: ( ) E-mail Address:
PERMANENT HOME ADDRESS *(If different)* Address: City/ State/ Zip:	
EMERGENCY CONTACT	**EMERGENCY CONTACT NUMBERS**
Name: Relationship: Address: City/ State/ Zip:	Home Phone: Cell Phone: Work Phone:

CAMPUS LOCATION *(check one)*					TERM ENTERING *(check one)*			YEAR ENTERING
Oakland	SF Peninsula	Sacramento	Fresno	Online	Fall	Spring	Summer	

ACADEMIC PROGRAM ENTERING *(check one)*										
RN-BSN	BSN	ABSN	ELMSN, CM, FNP FNP/DNP, DNP	CLE	SW	CRNA	MPA	DPT	MOT/OTD	DPM

Consent for Treatment and Limited Release of Records

CONFIDENTIALITY: Unless you give permission, no confidential information (other than as indicated below) is provided to any other department of the University or to anyone or other organization outside the University. In addition, the information you provide on these forms is not seen by the Admission staff and does not impact consideration of your application for admission.

TREATMENT: I hereby authorize Student Health & Counseling Center / Summit Medical Center to provide such medical services as deemed necessary during the period of time that I am a student at Samuel Merritt University.

LIMITS OF RELEASE OF RECORDS: I give permission for Samuel Merritt University Student Health & Counseling Center to make available information regarding dates of my completion of physical exams, immunization requirements and PPD testing results to my clinical instructors and to the clinical institutions where I will train.

The information provided above and on the attached forms is complete and true to the best of my knowledge.

Student Signature:_____ Date_____

Parent or Guardian Signature:_____ Date_____
(For students under 18 years old)

PRINT Student Name:_____

Consent to Release Records

I, (print name clearly)_____, hereby give my consent to Samuel Merritt University to release any and all of the following information to clinical agencies and training sites that are part of my clinical experiences, for my education at Samuel Merritt University.

I, (print name clearly)_____, hereby give my consent to Student Health at Samuel Merritt University to release my immunization records including but not limited to immunization dates and results, lab results, and my TB Skin Test results to my educational department to share with clinical agencies and training sites that are part of my clinical experiences for my education at Samuel Merritt University.

- Name, local address, e-mail address, phone number
- Birth date
- Criminal Background check
- Immunization records and/or titers with dates and results
- TB Skin Test results
- Lab results
- Health Compliance Records
- Verification of health insurance (if applicable)
- Last 4-digits of social security number
- CPR
- Blood borne pathogen training dates (Health)
- HIPPAA training dates
- Health Care licensure (if applicable)

I understand that this information is used solely for the necessary operations at the clinical agencies and training sites, including but not limited to credentialing, computer access, medication systems, and building access during my clinical rotation.

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Signature of Student Date