ST MARY'S COLLEGE of MARYLAND
The National Public Honors College

Health Services

Demographic and Consent Form

Legal Name _____Date of Birth____ /___ /____ Student ID#_____

Preferred Name _____ Pronouns _____Email_____

Phone Number _____ Residential Hall & Room _____

Home Street Address _____

City _____ State _____ Zip Code _____

How may we reach you/leave a voicemail message, if needed? ☐ Phone ☐ Email ☐ Medicat (EMR) secure messaging

Emergency Contact (First and Last Name) _____

Relationship_____Phone Number _____

Address_____

This emergency contact is for Health Services only.

Please contact the Office of Residence Life to update your emergency contact information for other college records.

Consent for Treatment

I understand that the information gathered by the healthcare team during visits to SMCM Health Services is confidential. Health Services may share information with SMCM Counseling Services for non-urgent referrals with my permission. Otherwise, I understand that my health care information will not be shared outside of SMCM Health Services without my written consent UNLESS I am experiencing a medical or mental health emergency. If I require emergency treatment at SMCM Health Services or neighboring hospitals and am unable to provide consent for treatment, I hereby give permission for emergency medical treatment, including surgery, if deemed necessary and/or lifesaving by the provider rendering care.

IF A MINOR IS INVOLVED, ordinarily the provider will attempt to contact the parent or guardian before emergency medical treatment, including surgery, if deemed necessary and/or lifesaving by the provider rendering care.

☐ I agree and consent to treatment.
☐ I have read and understand the Privacy Notice *(hard copy available by request).*

Student Signature _____ Date _____

Parent/Guardian Signature_____ Print Name_____Date _____

If student is under the age of 18 years of age, parent/guardian signature is required for treatment in most situations