MARY BALDWIN UNIVERSITY

Health Center
PERMISSION TO TREAT

NAME: ____ **AGE:** ___________ **DOB:** _____/______/______

TODAY'S DATE: _____/_____/______

Circle all that apply: **PEG** **VWIL** **Athlete** **If athlete, what sport?** ____________________

Y / N Have you been experiencing symptoms of depression/anxiety? Mild Mod Severe

Y / N Would you be interested in speaking with a therapist? Already seeing therapist?

Y / N Are you having thoughts of hurting yourself or others?

REASON FOR TODAY'S VISIT:

____

ALLERGIES: ☐ **NO KNOWN DRUG ALLERGIES**

____

MEDICAL HISTORY: ☐ **NONE** ☐ Asthma ☐ Diabetes ☐ Autoimmune condition ☐ Cardiac ☐ Blood pressure

OTHER significant medical history: ____

MEDICATIONS you are taking including over-the-counter medicines, birth control and supplements:

☐ **NO MEDICATIONS**

1) ____ 4) ____

2) ____ 5) ____

3) ____ 6) ____

Provider/Patient Responsibilities

To help ensure that the students' needs are being met when seeking treatment at the Mary Baldwin Health Center, the following options will be available to them:

1. Students may ask at any time to have a nurse present during visits with our providers. Per Augusta Health policy, all gynecological care is provided with two clinicians present.
2. Students always have the option of seeing another provider in the community. The Health Center staff can assist in making recommendations and/or facilitate referrals. The student would be responsible for any costs incurred with seeing a provider outside of the health center.

Consent for Treatment

I hereby authorize the Mary Baldwin clinic staff to perform and hereby consent to such medical care as felt to be necessary, including examinations and treatments in the opinion of the healthcare provider to be medically necessary. I also reserve the right to refuse treatment and/or discharge myself from the care of the clinic by verbal or written notification.

Exposure Provision

If a health care provider or any employee of the Mary Baldwin Health Center is directly exposed to my blood or other body fluids in a manner which may transmit HIV, Hepatitis or other blood borne diseases, I hereby consent to be tested for the above viruses. I understand that positive results will also be disclosed as medically necessary in connection with medical treatment or as required/permitted by law.

________________________________ ____________________

Patient Signature **Date**