☐ F1 ☐ Health ☐ Student ☐ Staff

Santa Monica College – Health Services

Name _____ _____ _____ **Date** _____ **Time** _____
Last First MI

☐ Female ☐ Male ☐ Non-Binary **Are you Pregnant?** ☐ Yes ☐ No

Student ID _____ **Birth Date** _____ **Age** ___ **Phone** _____

Reason for Visit:

☐ Blood Pressure	☐ Hearing	☐ TB Test	☐ MD/NP Appointment
☐ Illness/Assessment	☐ Vision	☐ TB Read	☐ Condoms
☐ Telephone Consult	☐ Immunizations/Vaccines	☐ Medication	☐ Tampons/Pads
☐ Insurance Help	☐ First Aid	☐ Prescheduled	☐ Other

Are you interested in learning more about food security resources? ☐ Yes ☐ No

Are you interested in learning more about housing security resources? ☐ Yes ☐ No

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Seen by: ☐ RN ☐ MD ☐ NP ☐ HA ☐ Ledger ☐ Clinix ☐ ISIS

_____

_____

_____

_____

Ref: ☐ On Campus _____ ☐ Off Campus _____ ☐ Paid _____

I, _____,
Print Last Name, First Name

Hereby release SMC Health Services of any liability associated with the administration of medications, venipuncture, and/or treatment.

Medication taken in the last 24 hours

_____

_____

Medical Allergies

_____

Are you pregnant? ☐ Yes ☐ No

Drug & Dosage _____

Reason Needed _____

_____

_____ _____
Signature Age

_____
Administered by

_____ _____
Date Time

I, _____,
Print Last Name, First Name

Authorize SMC Health Services to release health information on:

Health History _____

Physical Exam _____

Other (specify) _____

Treatment Refusal _____

_____

_____

_____

_____

_____
Signature

_____
Date