OXNARD COLLEGE STUDENT HEALTH CENTER
4000 S. ROSE AVE.
OXNARD, CA 93033
(805) 678-5832

CONSENT FOR TREATMENT

STUDENT_____ STAFF_____ STUDENT ID#_____

LAST NAME: _____ FIRST NAME: _____ MIDDLE: _____

BIRTH DATE: _____ SEX: _____

ADDRESS:_____ CITY: _____STATE: _____ZIP CODE: _____

HOME NUMBER: _____ CELL PHONE: _____

EMAIL: _____

Would you like to subscribe to our Oxnard College Student Health 101(FREE online health magazine)? YES NO

EMERGENCY CONTACT: _____ PHONE: _____

REALTIONSHIP: _____

INSURANCE: YES NO IF YES, _____ Primary Care Doctor: _____Phone: _____

CONSENT FOR TREATMENT AND LIMITS OF CONFIDENTIALITY

I HEREBY GRANT OXNARD COLLEGE STUDENT HEALTH SERVICES PERMISSION TO TREAT AND/OR MAKE NECESSARY REFERRALS FOR MEDICAL/PSYCHOLOGICAL CARE, IF NEEDED. I UNDERSTAND THAT MY MEDICAL/PSYCHOLOGICAL RECORDS ARE KEPT CONFIDENTIAL IN ACCORDANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) PRIVACY PRACTICES. I HAVE RECEIVED AN OVERVIEW OF THE VENTURA COUNTY COMMUNITY COLLEGE DISTRICT STUDENT HEALTH CENTER NOTICE OF PRIVACY PRACTICES. I UNDERSTAND I MAY REQUEST A COPY OF THE POLICY IN ITS ENTIRETY AT ANY TIME. I ALSO UNDERSTAND THERE IS A COPY OF SAID POLICY POSTED IN THE STUDENT HEALTH CENTER FOR MY REVIEW.

I ALSO GIVE CONSENT FOR OCSHC STAFF TO EMAIL, CALL, OR LEAVE A VOICEMAIL AT ANY OF THE CONTACT INFORMATION I PROVIDED ABOVE._____ (PLEASE INITIAL)

SIGNATURE: _____ DATE: _____

ALLERGIES TO MEDICATION/FOOD: **REACTION:**

_____

CURRENT MEDICATION:

_____

OXNARD COLLEGE STUDENT HEALTH CENTER

NAME:_____ **BIRTHDATE:**_____ **TODAY'S DATE:**_____

CONFIDENTIAL MEDICAL/ HEALTH HISTORY

History	YES OR NO: Please explain if answer is "yes"	History	YES OR NO: Please explain if answer is "yes"
Headaches/Migraines/Head Injury/Concussion		Experiencing Stress	
Hearing Problems		Eating Disorder	
Vision Problems		Number of hours of sleep per night	
Epilepsy/Seizure		Smoke/Chew Tobacco/E-Cigs	
Asthma		Does anyone in your household smoke?	
Cancer			
High Cholesterol		Average weekly use of alcohol?	
Diabetes		Recreational Drug Use?	
Anemia		If so, what?	
High Blood Pressure		Current medications/herbs/supplements	
Heart Disease/Murmur			
Blood Clots		**Females**: First day of last period?	
Stroke		Are you or could you be pregnant?	
Kidney Disease			
Liver Disease/Hepatitis		**Family History**	**YES OR NO: If so, Who?**
Ulcers/ Stomach Problems		I Don't Know My Family History	
Hernia		Heart Disease or Heart Attack	
Joint Pain		High Blood Pressure	
Neck or Back Pain		Stroke	
Thyroid Disease		Blood Clots	
Surgery		Diabetes	
Have you ever been hospitalized?		High Cholesterol	
Do you have a primary care provider?		Cancer	
Are you being treated for any illnesses?		If So, What Kind Of Cancer?	
Any other health issues that you would like us to be aware of?		Mental illness	

FOR YOUR INFORMATION:

This office may use student workers to assist with health services. The person who checks your "vitals" – blood pressure, pulse, etc. may not be a licensed nurse. The students are qualified to take your vital signs; however, they are NOT qualified to suggest treatments and/or a diagnosis. You are not required to tell them the reason for your visit unless you are comfortable doing so. You may state "Confidential" regarding the reason for the visit. **Please Initial:** _____

Signature: _____

OXNARD COLLEGE STUDENT HEALTH CENTER

Fee Payment Information

We are committed to providing you with quality and affordable health care.

1. **Services that require additional fees over and above the mandatory student health fee:**
   - ***Physicals** – EMT, Dental Hygiene, Dental Assist., Nursing, CNA, Child Dev.
   - ***Vaccinations** – MMR, Flu, TDAP, Hep B, TB Skin Test
   - ***In House Prescriptions** – Antibiotics
   - ***Lab** – Blood tests, Pregnancy tests, Strep throat test, Wound culture

   All students will be provided a receipt for any billable service and must provide payment to the Student Business Office after your office visit. These fees are also posted to your student account and can be paid online. Please allow 2-3 days for fees to post online.

2. **Insurance** – We **do not** bill health insurance plans.

Please let us know if you have any additional questions regarding this information.

I have read and understand the above information and agree to abide by these guidelines:

_____	_____
Print Name	**Student ID #**
_____	_____
Signature of Student	**Date**

OXNARD COLLEGE STUDENT HEALTH CENTER

NAME: _____ **STUDENT ID#:** _____

DATE: _____

The Oxnard College Student Health Center takes Intimate Partner Abuse very seriously. We are now screening all patients for abuse, so that we can help break the cycle of abuse and violence.

Please answer the following questions.

1. In general, how would you describe your relationship?
    - A lot of tension
    - Some tension
    - No tension
2. Do you and your partner work out arguments with:
    - Great difficulty
    - Some difficulty
    - No difficulty
3. Do arguments ever result in you feeling down or bad about yourself?
    - Often
    - Sometimes
    - Never
4. Do arguments ever result in hitting, kicking or pushing?
    - Often
    - Sometimes
    - Never
5. Do you ever feel frightened by what your partner says or does?
    - Often
    - Sometimes
    - Never
6. Has your partner ever abused you physically?
    - Often
    - Sometimes
    - Never
7. Has your partner ever abused you emotionally?
    - Often
    - Sometimes
    - Never

Reviewed by Provider, if positive: _____ Date: _____

NAME:_____ DOB:_____ 900#_____ DATE: _____

Oxnard College Mental Health Screen

Please complete the front and back sections of this form

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "✔" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING __0__+_____+_____+_____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work/school, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Staff Only: Date reviewed _____ Date entered in EHR _____ Initial _____

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Please answer the following questions by placing a check in the YES or NO box	Past month	
Questions 1 and 2	**YES**	**NO**
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***Have you had any actual thoughts of killing yourself?***		
If YES to 2, answer questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) ***Have you been thinking about how you might do this?*** e.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it.*"		
4) ***Have you had these thoughts and had some intention of acting on them?*** as opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		
6) ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES,** ***Was this within the past 3 months?***	**Lifetime** **Past 3 Months**	