Icahn School of Medicine at Mount Sinai

Student Health Center
One Gustave L. Levy Place, Box 1260
New York, NY 10029-6574
Telephone: (212) 241-6023
E-mail: studenthealth@mssm.edu

Student Consents

Name (First, Middle, Last)	Date of Birth (MM/DD/YY)	Telephone	E-mail address
Preferred Gender Pronoun	**Gender**	**Gender Identity**	**Program accepted into:**
Emergency contact name	**Emergency contact relationship to you**	**Emergency contact telephone**	

Please sign all three and submit

CONSENT FOR PROVIDER - PATIENT COMMUNICATION

I consent that the staff at Student Health Center may communicate with me and/or members of their staff via secured Mount Sinai email and MyChart, Mount Sinai Hospital's electronic patient portal.

I consent that Student Health staff may communicate with other specialists (such as cardiologist, dermatologist, radiologist, pharmacist, billers etc.) if necessary to provide me with optimal, timely and personalized care.

I understand that e-mail services other than secured Mount Sinai email portals (Outlook and MyChart) do not offer patient protections and are not confidential methods of communicating with the Student Health staff about medical care. Communications via non-secure networks may be intercepted by third parties and/or transmitted to unintended parties resulting in breeches in confidentiality.

I understand that in an urgent or emergent situation I should call my provider or go to the Emergency Room and not rely on e-mail or MyChart.

By signing the below, I attest that I have read and agree to the terms in the Consent for Provider-Patient Communication in its entirety and have had my questions regarding the consent answered to my satisfaction.

E- Signature:	Today's date:

GENERAL CONSENT TO TREATMENT

I authorize the staff at Student Health Center to conduct diagnostic examinations, administer vaccines and medications and provide treatments or therapies necessary to maintain my health. I understand that the health care provider will explain to me the purpose of tests or procedures and available treatment options.

I have read the below information regarding the HIV virus, HIV testing/screening and how my HIV-related information will be kept confidential. I understand that my HIV test will result in EPIC and be viewable in MyChart. I understand that I can verbally or in writing Opt-Out of screening for HIV at any time. https://www.cdc.gov/hiv/clinicians/screening/index.html

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By signing the below, I attest that I have read and agree to the terms in the General Consent to Treatment in it entirety and have had my questions regarding the consent answered to my satisfaction.

E- Signature:	**Today's date:**

MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE

New York State Public Health Law requires that all college and university students enrolled for at least six (6) semester hours or the equivalent per semester ***or*** at least four (4) semester hours per quarter attest to the following:

☐ I have had the Meningococcal conjugate or MenACWY vaccines (Menactra® and Menveo®)
Date of vaccination must be **within the past 5 years**
Received meningococcal vaccine on (MM/DD/YYYY): _____ ***(Please provide proof of vaccine status)***

☐ I have read https://www.cdc.gov/vaccines/vpd/mening/index.html or have had explained to me the information regarding meningococcal meningitis. I will obtain immunization against meningococcal meningitis **within 30 days** from my private health care provider, Student Health Center,* or other health facility. ***(Please provide proof of vaccine status if obtaining elsewhere)***

☐ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I will **not** obtain immunization against meningococcal meningitis disease.

E- Signature:	**Today's date:**

* The Student Health provider will write a prescription for the vaccine. If you opt for the Student Health Aetna Insurance, you can fill it at the MSH Employee Pharmacy for $20. If not, the cost will depend on your prescription insurance.