STUDENT HEALTH & WELLNESS CENTER

GENERAL CONSENT TO TREAT

The undersigned patient and/or responsible relative or person hereby consent to and authorize College of the Canyons’ Student Health & Wellness Center physicians and medical personnel to administer and perform any and all medical examinations, treatments, designated procedures, vaccinations and immunizations against disease which may be now or during the course of the patient’s care as an outpatient be deemed advisable or necessary.

The undersigned also consents to the release of medical information to other institutions accepting the patient for medical care relative to continuity of care for this visit.

Date: ____________________

________________________  __________________________  ________________________
Signature of Witness      Signature of Patient       Name of Patient

________________________  __________________________  __________________________
Signature of Witness      Signature of Responsible Relation or Person  Name of Responsible Relation or Person

5/00
COLLEGE OF THE CANYONS  
STUDENT HEALTH & WELLNESS CENTER

Date: ______________

Name:__________________________   Student ID #:_____________________

Emergency Contact:

Name                                              Phone #                           Relationship

Personal History:

1. Medication Allergies: ________________________________

2. Medications used regularly: (i.e. thyroid, birth control, insulin, etc.):

3. Any regular use of alcohol, Marijuana, sleeping pills, street drugs, or tranquilizers?

   ___________         If yes, please identify: ______________________________

4. Do you smoke?____________   How many per day?________________

5. Past major medical illnesses, accidents, surgeries?

6. Any physical handicaps? (i.e., vision, hearing, etc.) Please describe:

7. Do you have a personal physician? ____________

   Name:______________________________Phone:______________________

8. Do you have health insurance? ________________

   Name:________________________________________________________________

9. Any other health issues or concerns? Please list:

   ____________________________________________________________