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

STUDENT HEALTH & WELLNESS CENTER

Student SS #: ____ Date: ________________

Last Name: _________________________ First Name: __________________ Initial: _________

Address: ___________________________City, State, Zip_________________________________

Telephone: _________________________ Birth Date: _______________ Sex: M F

Email:______________________ ____

EMERGENCY CONTACT:

Name: _____________________ Telephone #:________________ Relationship: _____________

Medication Allergies: ____

Reason for Visit: ____

I consent to participate in CAIR: Yes: _____ No:_____

STUDENT HEALTH & WELLNESS CENTER

Student SS #: ____ Date: ________________

Last Name: _________________________ First Name: __________________ Initial: _________

Address: ___________________________City, State, Zip_________________________________

Telephone: _________________________ Birth Date: _______________ Sex: M F

Email:____

EMERGENCY CONTACT:

Name: _____________________ Telephone #:________________ Relationship: _____________

Medication Allergies: ____

Reason for Visit: ____

I consent to participate in CAIR: Yes:______ No:______

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:

 ____