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:

 ____________________________________________________________