USC Engemann Student Health Center

Place Patient Label Here

Medical History and Consent for Medical Treatment
Summer Programs and
Non-Matriculating Students

Section 1. Patient/ USC Program Participant Information

↓**Legal Name for Patient/Participant** (Last, First, Middle): **Preferred Name:** **If applicable, USC ID # :**

Local Home Address: (*Street, City, State, Zip)* ☐ **Cell** ☐ **Home Phone** (Include area code)**:**

Date of Birth:_____/_____/_____
MM DD YY

Gender:
☐ **Female**
☐ **Male**

USC Program Name:
_____

From: _____/_____/_____
MM DD YY

To: _____/_____/_____
MM DD YY

Are you a MINOR (under 18 years of age)?
☐ **No**
☑ **Yes** →

California Family Code §6910 expressly provides that a parent or legal guardian may authorize an adult or entity into whose custody a child is entrusted to consent to necessary medical treatment. In the best interest of your child, the Engemann Student Health Center seeks such written authorization.

Print Name of Parent/Legal Custodian:_____

Mother's Maiden Name:

Section 2. Consent by adult (over 18) participant or legal custodian

1. General Consent for Treatment. I voluntarily consent to and authorize the USC Engemann Student Health Center (ESHC) to administer routine medical care and treatments, which may include, but is not limited to physical examination, diagnostic tests, medical procedures and medications as deemed necessary or advisable by an ESHC clinician. I understand and agree that I might receive care from a physician who does not hold a physician's and surgeon's certificate but who is qualified and certified by the California Medical Board to provide care in a special program as a visiting professor or faculty member. I am aware that the practice of medicine is not an exact science, and I acknowledge that ESHC makes no guarantees to me as to the result of tests, examinations, treatments, procedures or any other services rendered.
2. Rights and Responsibilities. I have been made aware of my rights and responsibilities as posted in the ESHC waiting areas and website. These responsibilities include but are not limited to: personal financial responsibility for any charges not covered by insurance or the USC Student Health Fee, following provider prescribed treatment plan, participating in care, behaving respectfully during visit and the right to change provider if other qualified providers are available.

Signature:
_____

Relationship to participant:
☐ **Self** ☑ **Parent** ☐ **Legal Custodian**
☐ **Other:**_____

Today's Date:
_____/_____/_____
MM DD YY

Section 3. Emergency Contact (Must be a relative or friend who is over the age of 18 years of age)

↓**Name (Last, First):** **Relationship:** ☐ **Cell** ☐ **Home Phone:** *(Include area code)*

Name (Last, First): **Relationship:** ☐ **Cell** ☐ **Home Phone:** *(Include area code)*

Section 4. Health Insurance Information: (Insurance coverage for patient/ program participant)

Please attach a copy (front/back) of the patient/participant insurance card and submit it with this form

↓**Name of Insurance Carrier** **Name of Insured on Card:** (May be spouse/parent name) **Policy #:** **Policy Telephone #:**

Name of Personal Physician ☐ **Office** ☐ **Cell Phone:** *(Include area code)*

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Legal Name (Last, First, Middle Initial)**:** **Preferred Name:** **Date of Birth** (MM/DD/YY)**:**

Section 5. Non-USC student ONLY

If you are a visitor on campus or are a non-USC student, please indicate your ethnic background:

☐ Asian/ Pacific Islander	☐ Multi-Racial (Reported as Unknown)	☐ International Student (Reported as Unknown)
☐ Black non-Hispanic	☐ Native American	☐ Unknown
☐ Hispanic/Latino	☐ White non-Hispanic	

Section 6. Medical History

Please provide to the best of your knowledge, complete and accurate information about your/participant's health history, medications (including over-the-counter products and supplements), allergies or sensitivities.

General Medical Information

1. Have you received a tetanus shot within the last 10 years? ☐ **Yes** ☐ **No** ☐ **Unsure**

Allergies (Food, Medicine, Insects, Plants…etc)

Allergy	Type of reaction	Allergy	Type of reaction
1.		**4.**	
2.		**5.**	
3.		**6.**	

Current Prescribed Medications

(List all prescribed medications, including topicals, inhalers and contraceptives.)

Medication	Dosage, if known	Medication	Dosage, if known
1.		**4.**	
2.		**5.**	
3.		**6.**	

Current Herbal/Vitamins or Non-Prescribed Medications

Medication	Dosage, if known	Medication	Dosage, if known
1.		**4.**	
2.		**5.**	
3.		**6.**	

Illness / Injuries (Significant medical or chronic conditions)

1.	**3.**	**5.**
2.	**4.**	**6.**

Surgeries/ Hospitalizations

Year	Reason	Year	Reason
1.		**4.**	
2.		**5.**	
3.		**6.**	