

**CONFIDENTIAL**  
**REGISTRATION & CONSENT FOR TREATMENT**

Name \_\_\_\_\_  
Local address & city \_\_\_\_\_  
Phone \_\_\_\_\_

HSU ID # \_\_\_\_\_  
Date of birth \_\_\_\_\_

In case of emergency, notify: \_\_\_\_\_  
Address & City \_\_\_\_\_

Relationship \_\_\_\_\_  
Phone \_\_\_\_\_

**INSURANCE INFORMATION**

- Currently I have no health insurance coverage.
- I have the following health insurance coverage:  
(attach copy of insurance card)

Company \_\_\_\_\_ Phone \_\_\_\_\_  
Name of subscriber (self, parent, etc.) \_\_\_\_\_  
Insurance Number \_\_\_\_\_ Effective date \_\_\_\_\_

**Personal and Family History**

**Health History**

Have you ever been hospitalized?  Yes  No  
\_\_\_\_\_  
\_\_\_\_\_

Have you had any serious injuries &/or surgeries?  Yes  No  
\_\_\_\_\_  
\_\_\_\_\_

Have you received counseling or other treatment for alcohol / substance abuse, eating disorder, or other emotional or psychiatric problem?  Yes  No  
\_\_\_\_\_  
\_\_\_\_\_

Have any of your relatives had serious Medical illnesses? (e.g., alcoholism, heart Attack, psychiatric, diabetes, high blood pressure? (If yes, list relation and illness.)  Yes  No  
\_\_\_\_\_  
\_\_\_\_\_

Do you regularly fasten your seat belt in a car?  Yes  No

Do you regularly use a helmet when riding a skateboard, motorbike or bicycle?  Yes  No  N/A

Please describe any YES responses. Use back of sheet, if needed.

Are you allergic to any medications?  Yes  No  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any significant on-going health problems?  Yes  No  
\_\_\_\_\_  
\_\_\_\_\_

Do you take/use medications, Birth Control, Vitamins or natural remedies regularly?  Yes  No  
\_\_\_\_\_  
\_\_\_\_\_

Do you know about the "morning after" pill?  Yes  No  
(Plan B, emergency oral contraception)

Have you had a positive TB skin test?  Yes  No  
If yes, did you take INH?  Yes  No  
If yes, when? \_\_\_\_\_

**Authorization and Consent for Treatment**  
Parent / Guardian signature is also required if you are under the age of 18.

I hereby give consent to the medical staff at the HSU Student Health Center for medical examination and treatment. This includes lab and X-ray tests, administration of drugs, or any other care when deemed advisable by, and rendered under the general supervision, of a physician licensed under the provision of the California Medical Practice Act. I understand that treatment will be completely confidential and my records will not be released to anyone without my permission except by subpoena and legal required morbidity reporting.

Student Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_