Humboldt State University
Student Health Center

Tel: 707-826-3146
Fax: 707-826-5042

CONFIDENTIAL
REGISTRATION & CONSENT FOR TREATMENT

Name _____ HSU ID # _____

Local address & city _____ Date of birth _____

_____ Phone _____

In case of emergency, notify: _____ Relationship _____

Address & City _____ 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

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

Health History

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: _____