Student Health and Counseling Center
California State University, Fresno
5044 N. Barton Avenue MS/HC81
Fresno, Ca 93740-8012

AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT

The undersigned (Parent/Guardian) of _____

Who is _____ years old, hereby authorizes the medical staff of University Health and Psychological Services of California State University, Fresno, as agents for the undersigned to consent to any diagnostic procedure (including x-ray), and the administration of any medical or surgical treatment, when any or all of the foregoing is deemed advisable by and is to be rendered under general supervision of any physician and surgeon licensed under the Provision of the Medical Practice Act.

This authorization is given in advance of any special diagnosis, treatment or medical care being required, and pursuant to the provisions of Section 25.8 of the California Civil Code.

_____ _____
Date Parent / Guardian Signature

_____
Print Name

California State University, Fresno University Health & Psychological Services

Confidential Health History

Name _____ Student ID _____
Last First M.I.

Local Address _____ Date of Birth _____

Telephone _____ Email Address _____
Cell Home

May we use phone for confidential message? ___Cell ___Home ___Neither

Gender____ Marital Status: __ Single __ Married __ Divorced __ Widowed Primary Language_____

Country of Birth_____Are you covered by health insurance? ___No ___ Yes Name of Ins. Company_____

Person To Notify In Case of Emergency_____Relationship_____

Address_____Phone_____

List *ALL* medications you currently take (include birth control pills or shots and over-the-counter medications or supplements):

_____

_____

List *ALL* allergies/sensitivities to medications or other substances with type of reaction:

_____

_____

Personal Medical History Have you had or do you have any of the following? **Check all that apply & give details below**

__ Allergies
__ Anemia
__ Anxiety or Panic Attack
__ Asthma
__ Cancer
__ Concussion/ Head Injury
__ Depression
__ Diabetes
__ Eating Disorder
__ Headache Migraine
__ Headache Recurrent
__ Heart Disease
__ Hepatitis
__ High Blood Pressure
__ High Cholesterol
__ Hospitalization
__ Kidney disease
__ Liver disease
__ Loss of Consciousness
__ Mononucleosis
__ Overweight/Obesity
__ Psychiatric Problems
__ Seizures
__ Sexually Transmitted Infection
__ Sleep Apnea
__ Stomach/Intestinal Problems
__ Stroke
__ Substance Abuse
__ Surgery
__ Thyroid Disease
__ Tuberculosis
__ Blood Clots / DVT
__ Positive TB skin test
__ Serious Injury
__ Hearing Loss
__ Vision Impairment
__ Other_____
_____
_____
__ No Medical Problems

Details of above _____

_____

Family Medical History Have any of your relatives (parents, grandparents, siblings or children) had any of the following?
Check all that apply and list which relative

___ I don't know any family history
___ Alcoholism_____
___ Allergies_____
___ Asthma_____
___ Bleeding Problems_____
___ Blood Clots_____
___ Cancer_____
Type of Cancer_____
___ Diabetes_____
___ Drug Abuse_____
___ Heart Disease_____
___ High Blood Pressure_____
___ High Cholesterol_____
___ Kidney Disease_____
___ Melanoma_____
___ Mental Illness_____
___ Migraine Headache_____
___ Stroke_____
___ Thyroid Disease_____
___ Tuberculosis_____
___ Other_____
_____

Please Turn Over & Complete Other Side

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California State University, Fresno University Health & Psychological Services

Confidential Health History

Health Habits

Do you now use any of the following?
__ Tobacco
__ Marijuana
__ Other recreational drugs
__ Stimulants (non-medical use)
__ Other prescription drugs (non-medical use)

How often do you consume alcohol?
__ Never
__ Once/month or less
__ 2-4 times/month
__ 2-3 times/week
__ 4 or more times/wk

When you drink alcohol, how much do you typically drink in one day?
__ < 1 alcoholic beverages
__ 1-2
__ 3-4
__ 5 or more

Have you ever felt you should cut down on drinking alcohol? ___ Yes ___ No

Do you exercise regularly? ___Yes ___ No If yes, type of exercise & how often _____

Do you have concerns about your diet or nutrition? ___Yes ___No

Do you use 'safer sex' practices? ___ Always ___Sometimes ___ Never ___Abstinence

Is anyone, including your partner, threatening you, hurting you physically, or causing you to be afraid? ___ Yes ___No

Immunizations

Have you completed the series for Hepatitis B immunization? ___ Yes ___No ___Not Sure

Have you had ___Chicken Pox ___Varicella vaccine ___Neither ___Not Sure

Have you received the vaccine for HPV (Gardasil)? ___Yes ___No ___Not Sure

Have you received an immunization for meningitis? ___Yes ___No ___Not Sure

I authorize the University Health Services at California State University, Fresno to provide, at my request, all ordinary medical examinations and treatment, as well as any necessary emergency care. I am aware that State Law requires the medical provider to report certain conditions such as injury due to violent assault, loss of consciousness, public health diseases and being a danger to self or others.

_____ _____
Signed Date

_____ _____
Reviewed By Date