Humboldt State University
Student Health Center

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

CONFIDENTIAL
REGISTRATION & CONSENT FOR TREATMENT

Name ______________________ HSU ID # ______________________
Local address ______________________ Date of birth ______________________
______________________ Phone ______________________ ☐ Female ☐ Male

In case of emergency, notify: ______________________ Relationship ______________________
Address ______________________ Phone ______________________

INSURANCE INFORMATION

☐ Currently I have no health insurance coverage.
☐ I have the following health insurance coverage: *(or attach insurance card)*

Company ______________________ Phone ______________
Name of subscriber (self, parent, etc.) ______________________
Group Number ______________________ Effective date _______

Personal and Family History

Have you ever been hospitalized? ☐ Yes ☐ No
____
____
____

Have you had 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
____
____
____

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 health problems? ☐ Yes ☐ No
____
____
____

Do you take medications regularly? ☐ Yes ☐ No
____
____
____

Date of last TB skin test ______________________

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: ______________________