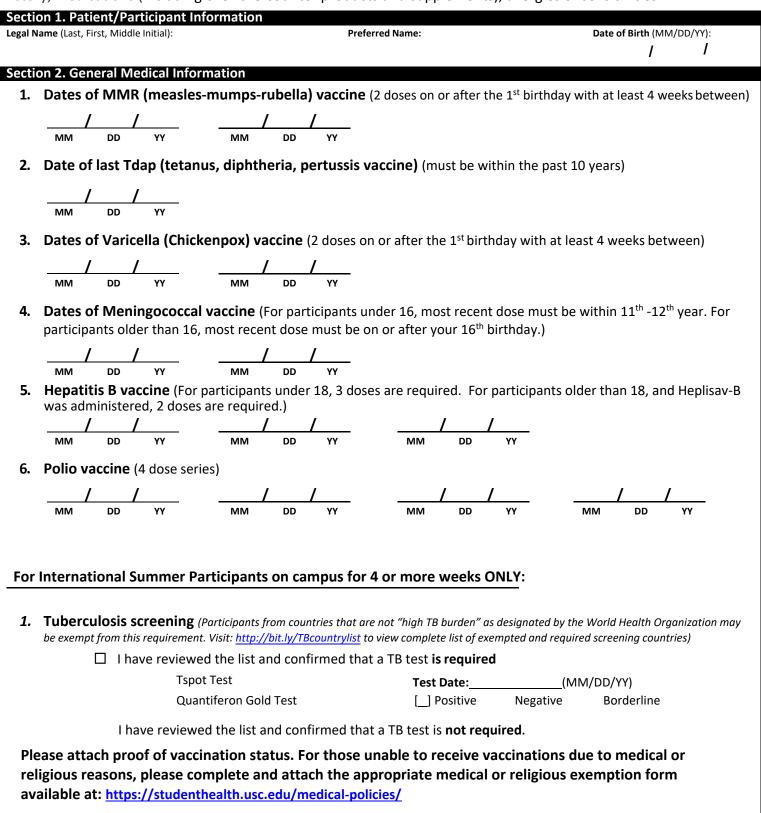
## USC Student Health

Keck Medicine of USC

	er Program Participant Information appears on insurance information (Last, First, Middle):	Preferred Name: If applicable, USC ID #:				
Local Home Address: (Street, City, State,	Postal Code, Country)					
Preferred Phone:	Email:	USC Program Name:				
Date of Birth: / / MM DD YY	Sex assigned at birth: Female Male Unknown Gender Identity:	Program Dates: From: / / MM DD YY To: / /				
Are you a MINOR (Under 18 years of age)?	authorize an adult or entity into whose	MM DD YY provides that a parent or legal guardian may custody a child is entrusted to consent to st interest of your child, the USC Student n.				
□ Yes →	Print Name of Parent/Legal Custodian:					
	Mother's Maiden Name:					
<ul> <li>USCSH physician. I am a there are no guarantees rendered.</li> <li>2. Rights and Responsibility waiting areas and websi</li> </ul>	ware that the practice of medicine is not a s as to the result of tests, examinations, tro ties. I have been made aware of my rights	eatments, procedures or any other services and responsibilities as posted in the USCSH nation of any service charge incurred and my				
Signature:	Relationship to participant: Self Parent Legal Cu Other	ustodian MM / DD / YY				
Section 3. Emergency Contact Name (Last, First):	(Must be the parent/legal guardian in additi Relationship:	ion to a relative or friend over 18 years of age)				
Name (Last, First):	Relationship:	<b>Cell Home Phone:</b> (Include area code,				
Section 4. Health Insurance In Please attach a Name of Insurance Carrier	formation: (Insurance coverage for patient/ copy (front/back) of the patient/participant insura Name of Insured on Card: (May be spouse/parent name	ance card and submit it with this form				

## USC Student Health

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.



## USC Student Health

Keck Medicine of USC

Section 1. Patient/Participant Informatio	n						
Legal Name (Last, First, Middle Initial):	Preferre	d Name:	Da	ate of Birth (MM/DI	D/YY):		
				1	1		
				-	•		
Allergies (Food, Medicine, Insects, Plantsetc)							
Allergy Typ	e of reaction	Allergy		Type of reaction	on		
1.		4.					
2.		5.					
3.		6.					
		-					
Current Prescribed Medications							
(List all prescribed medications, including topicals, i	inhalers and contraceptives	5.)					
	age, if known	Medication		Dosage, if kno	wn		
1.	-8-,	4.					
2.		5.					
3.		6.					
5.		0.					
Current Herbal/Vitamins or Non-Prescrib	ed Medications						
	e of reaction	Medication		Dosage, if kno	wn		
1.		4.					
2.		5.					
3.		6.					
Illness/Injuries (Significant medical or ch							
1.	3.		5.				
2.	4.		6.				
Surgeries/Hospitalizations							
	ison	Year		Reason			
1.		4.					
2.		5.					
3.		6.					