USC Student Health
Keck Medicine of USC

Place Patient Label Here

Medical History and Consent for Medical Treatment
Summer Programs

Section 1. Patient/USC Summer Program Participant Information

Legal Name for Patient/Participant as it 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: ____/____/____ (MM DD YY)

Are you a MINOR (Under 18 years of age)?

☐ **No**

☐ **Yes** →

California Family Code §6910 expressly provides that a parent or legal guardian may authorize an adult or entity into whose custody a child is entrusted to consent to necessary medical treatment. In the best interest of your child, the USC Student Health seeks such written authorization.

Print Name of Parent/Legal Custodian: _____

Mother's Maiden Name: _____

Section 2. Consent by adult (over 18) participant or legal custodian

1. **General Consent for Treatment.** I voluntarily consent to and authorize the USC Student Health (USCSH) to administer medical care and treatment(s) to the Participant, which may include, but is not limited to physical examination, diagnostic tests, medical procedures and medications as deemed necessary or advisable by an USCSH physician. I am aware that the practice of medicine is not an exact science, and I acknowledge that there are no guarantees as to the result of tests, examinations, treatments, procedures or any other services rendered.
2. **Rights and Responsibilities.** I have been made aware of my rights and responsibilities as posted in the USCSH waiting areas and website; including my right to receive an explanation of any service charge incurred and my financial responsibility for any charges not covered by the USC Student Health Fee.

Signature: _____

Relationship to participant:
☐ **Self** ☐ **Parent** ☐ **Legal Custodian**
☐ **Other** _____

Today's Date: _____
MM / DD / YY

Section 3. Emergency Contact (Must be the parent/legal guardian in addition to a relative or friend over 18 years of age)

Name (Last, First): **Relationship:** ☐**Cell** ☐**Home Phone:** *(Include area code)*

Name (Last, First): **Relationship:** ☐**Cell** ☐**Home Phone:** *(Include area code)*

Section 4. Health Insurance Information: (Insurance coverage for patient/program participant)

Please attach a copy (front/back) of the patient/participant insurance card and submit it with this form

Name of Insurance Carrier **Name of Insured on Card:** (May be spouse/parent name) **Policy #:** **Policy Telephone #:**

Name of Personal Physician ☐**Office** ☐**Cell Phone:** *(Include area code)*

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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.

Section 1. Patient/Participant Information

Legal Name (Last, First, Middle Initial): **Preferred Name:** **Date of Birth** (MM/DD/YY): / /

Section 2. General Medical Information

1. **Dates of MMR (measles-mumps-rubella) vaccine** (2 doses on or after the 1st birthday with at least 4 weeks between)

   ___/___/___ (MM DD YY) ___/___/___ (MM DD YY)

2. **Date of last Tdap (tetanus, diphtheria, pertussis vaccine)** (must be within the past 10 years)

   ___/___/___ (MM DD YY)

3. **Dates of Varicella (Chickenpox) vaccine** (2 doses on or after the 1st birthday with at least 4 weeks between)

   ___/___/___ (MM DD YY) ___/___/___ (MM DD YY)

4. **Dates of Meningococcal vaccine** (For participants under 16, most recent dose must be within 11th -12th year. For participants older than 16, most recent dose must be on or after your 16th birthday.)

   ___/___/___ (MM DD YY) ___/___/___ (MM DD YY)

5. **Hepatitis B vaccine** (For participants under 18, 3 doses are required. For participants older than 18, and Heplisav-B was administered, 2 doses are required.)

   ___/___/___ (MM DD YY) ___/___/___ (MM DD YY) ___/___/___ (MM DD YY)

6. **Polio vaccine** (4 dose series)

   ___/___/___ (MM DD YY) ___/___/___ (MM DD YY) ___/___/___ (MM DD YY) ___/___/___ (MM DD YY)

For International Summer Participants on campus for 4 or more weeks ONLY:

1. **Tuberculosis screening** *(Participants from countries that are not "high TB burden" as designated by the World Health Organization may be exempt from this requirement. Visit: http://bit.ly/TBcountrylist to view complete list of exempted and required screening countries)*

   ☐ I have reviewed the list and confirmed that a TB test **is required**

   ☐ Tspot Test
   ☐ Quantiferon Gold Test

   Test Date:_____(MM/DD/YY)
   ☐ Positive ☐ Negative ☐ Borderline

   I have reviewed the list and confirmed that a TB test is **not required**.

Please attach proof of vaccination status. For those unable to receive vaccinations due to medical or religious reasons, please complete and attach the appropriate medical or religious exemption form available at: https://studenthealth.usc.edu/medical-policies/

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Section 1. Patient/Participant Information

Legal Name (Last, First, Middle Initial):

Preferred Name:

Date of Birth (MM/DD/YY):
/ /

Allergies (Food, Medicine, Insects, Plants…etc)

Allergy	Type of reaction	Allergy	Type of reaction
1.		4.	
2.		5.	
3.		6.	

Current Prescribed Medications

(List all prescribed medications, including topicals, inhalers and contraceptives.)

Medication	Dosage, if known	Medication	Dosage, if known
1.		4.	
2.		5.	
3.		6.	

Current Herbal/Vitamins or Non-Prescribed Medications

Medication	Type of reaction	Medication	Dosage, if known
1.		4.	
2.		5.	
3.		6.	

Illness/Injuries (Significant medical or chronic conditions)

1.	3.	5.
2.	4.	6.

Surgeries/Hospitalizations

Year	Reason	Year	Reason
1.		4.	
2.		5.	
3.		6.	