COLORADOSCHOOLOFMINES

OREDIGGER CAMP

HEALTH HISTORY/CONSENT TO TREAT

NAME_____ CWID#_____
LAST (FAMILY) FIRST MIDDLE INITIAL

DATE OF BIRTH_____ GENDER: ☐ F ☐ M ☐ OTHER

HOME ADDRESS_____
NUMBER AND STREET NAME CITY STATE ZIP CODE

HOME PHONE NUMBER_____ MOBILE PHONE NUMBER_____

_____ **PHONE NUMBER**_____
EMERGENCY CONTACT NAME **RELATIONSHIP**

PERSONAL HISTORY check box if your answer is yes.

☐ Asthma/Wheezing/Shortness of Breath ☐ Blood Disorder ☐ Depression/Anxiety/Panic
☐ Diabetes ☐ Fainting/Syncope ☐ Heart Problems
☐ Joint/Back Problems ☐ Seizures/Convulsions

OTHER HEALTH CONCERNS_____

MEDICATION ALLERGIES_____

OTHER ALLERGIES_____

Do you carry and Epipen?_____

Have you ever had any illnesses/injuries other than those noted (if yes, specify)?_____

Do you have any type of disability/condition which limits functioning (if yes, specify)?_____

Please list any drugs, medicines, vitamins, minerals, supplements you use:_____

_____

The above information is correct to the best of my knowledge. _____
Student Signature (if age 18 or over) **Date**

TO PARENT OR GUARDIAN OF MINOR STUDENTS (under age 18):
I consent to have my son/daughter receive routine treatment at the Coulter Student Health Center or local hospital or medical center should he/she become ill or injured while at school and school sponsored activities.

I understand that should my minor child need more invasive diagnostic or surgical procedures, attempts will be made to contact me before such care is initiated. I further understand that, once my child reaches the age of majority, my consent for treatment is no longer required.

Parent/Guardian Signature_____ **Date**_____

Printed Name_____**Relationship**_____