REPORT OF MEDICAL HISTORY & PARENTAL CONSENT FORM
Western Carolina University Health Services

PATIENT INFORMATION: please print

Name (Last Name, First Name, Middle Initial) ____________________

DOB ____________ / SSN ____________

Permanent Address ____________________

City, State, Zip ____________________

Home Phone # ____________________

GENDER: ☐ Male ☐ Female

PARENT/GUARDIAN INFORMATION:

Name (Last Name, First Name, Middle Initial) ____________________

Day Phone # ____________ / Evening Phone # ____________

Street Address ____________________

City, State, Zip ____________________

Hospital/Health Insurance Company Name ____________________

Name of Policy Holder ____________ / Policy # ____________

PERSONAL HEALTH HISTORY:

Illness/ Injury	Yes	No	Year	Illness/ Injury	Yes	No	Year	Illness/ Injury	Yes	No	Year	Illness/ Injury	Yes	No	Year
Eye Trouble				Asthma				Kidney or Bladder Disease				**FEMALES ONLY**			
Ear, Nose, Throat Problem				Frequent or Severe Respiratory Infections				Disease or injury of Bones or Joints				Irregular Periods			
Frequent or Severe Headaches				Rheumatic Fever				Stomach or Intestinal Trouble				Severe Cramps			
Epilepsy or Convulsions				High Blood Pressure				Anemia				Excessive Flow			
Tuberculosis				Heart Trouble, Murmur, or Irregularity				Diabetes				Abnormal PAP Smear			
				Hepatitis or Jaundice				Mononucleosis				Other: ____________			

History	Yes	No	Explanation
Are you undergoing treatment or do you have a disease which should be followed or periodically evaluated?			
Have you ever had a drug or food allergy or other sensitivity or intolerance?			
Have you had any illness, injury or operation or been hospitalized other than as already noted? Has your physical activity been restricted during the past five years?			
Have you ever been hospitalized for mental or emotional illness?			If so, please give name(s) and address (es) of doctor(s) and/or hospital(s):
Have you ever interrupted school or work either because of mental or emotional illness or after psychiatric consultation?			If so, please give name(s) and address (es) of doctor(s) and/or hospital(s):
Do you have any physical handicaps or disabilities that may restrict or limit in some way your physical activity?			

HEALTH/PHYSICAL ASSESSMENT: *THIS INFORMATION MUST BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER*

Name (Last Name, First Name, Middle Initial) ____________________

Date of Examination ____________________

Blood Pressure ______/______

Hearing RT ______/______ Hearing LT

Date of Last TD Booster (required within last 10 years) ____________________

Corrected Vision: RT ______/______

Corrected Vision: LT ______/______

Uncorrected Vision: RT ______/______

Uncorrected Vision: LT ______/______

Urinalysis: Sugar ________/ Albumin ________/ Micro. ________

HEIGHT: ________inches WEIGHT: ________lbs.

	Yes	No	Explanation
Is there loss or seriously impaired function of any paired organs?			
Do you recommend any limitations for physical activity?			
Do you have any recommendations regarding the care of this student?			
Is the student now under treatment for any medical or emotional conditions?			

PHYSICAL ASSESSMENT:
Are there abnormalities of the following systems? Please explain.

FAMILY HISTORY:
Is there any family history of the following?

System	Yes	No	Explanation	Illness	Yes	No	Relationship
Head, Ears, Nose, Throat				Tuberculosis			
Eyes				Diabetes			
Respiratory				Heart Disease			
Cardiovascular				Kidney Disease			
Gastrointestinal				Arthritis			
Genitourinary				Stomach Disease			
Hernia				Asthma, Hay Fever			
Musculoskeletal				Epilepsy or Convulsions			
Metabolic/Endocrine				High Blood Pressure			
Neuropsychiatric							
Skin							

Other Comments: ____

____

Print Name of Health Care Provider ____________________

Signature of Health Care Provider ____________________

Address ____________________

Phone # ____________________

AUTHORIZATION TO CONSENT TO HEALTH CARE FOR MINOR

University Health Services and other Area Treatment Facilities

This form must be completed. Information provided on this form will be kept strictly confidential and is for the sole use of WCU Health Services to provide care to the student while he/she attends this program. Medical services offered by the Summer Youth Program are confined to services rendered by WCU Health Services. In compliance with federal regulation 164.502 *Uses and disclosures of protected health information*: A covered entity (i.e. WCU Health Services) may not use or disclose protected health information (i.e. medical records), except to the individual; in compliance with a valid authorization (i.e. signed request for release of medical records); or to carry out treatment, payment, or health care operations. By signing this form you are agreeing to the above statement and giving consent to WCU Health Services' medical staff to provide medical care/treatment to you son/daughter.

I, ____________________________, of _________________County, ________, am the custodial parent having legal custody of ________________________________, a minor child, age ________, born ________________, ___________. I authorize **Western Carolina University and** ____ (title of conference or camp) to do any acts which may be necessary or proper to provide for the health care of the minor child, including, but not limited to, the power (i) to provide for such health care at any hospital or other institution, or the employing of any physician, dentist, nurse, or other person whose services may be needed for such health care, and (ii) to consent to and authorize any health care, including administration of anesthesia, X-ray examination, performance of operations, and other procedures by physicians, dentists, and other medical personnel except the withholding or withdrawal of life sustaining procedures. This consent shall be effective from the date of execution to and including ________________ **through ________________, 20______.**

By signing here, I indicate that I have the understanding and capacity to communicate health care decisions and that I am fully informed as to the contents of this document and understand the full import of this grant of powers to the agent named herein.

____ **(SEAL)** _____________________

Legal Parent **Date**

STATE OF ____________________________ COUNTY OF __________________________

On this ________day of ________________, _____________________________, personally appeared before me the named ________________________________, to me known and known to me to be the person described in and who executed the foregoing instrument and he (or she) acknowledges that he (or she) executed the same and being duly sworn by me, made oath that the statements in the foregoing instrument are true.

________________________________ _______________________________

Notary Public My Commission Expires:

(OFFICIAL SEAL).

(app.9/02)

Although it will not limit your child's access to this program, please be aware that failure to obtain a notary seal may limit or restrict his or her access to some regional hospitals and/or treatment facilities where their own policies may require this. The signature of a legal parent is mandatory and WCU reserves the right to deny the child participation without proper consent.