Office	Use	Only
RN	MD	PPD

SANTA CLARA UNIVERSITY

COWELL STUDENT HEALTH CENTER

PERSONAL HEALTH HISTORY

Deadline: September 1, 2007

A Physician's Signature is NOT REQUIRED to complete this form

Please mail this form to: Cowell Health Center, Santa Clara University, 500 El Camino Real, Santa Clara, CA 95053

The purpose of this form is to ensure that every student received optimal health care when visiting the Cowell Health Center. By having this information on file, the Cowell Halth Center Team will be able to better assist the student at the time of the visit.

STUDENT STATUS: (Circle) FR SO JR SR LAW GRAD

Name: _____ Sex M_____ F_____
Last First MI

Birthdate: _____ Student ID #: _____

Address: _____ Phone ( )_____
Street City State Zip

Parent/Guardian/Significant Other_____

Address: _____ Phone ( )_____
Street City State Zip Home

Phone ( )_____
Work

Height:	Weight:	Allergies: (Medications, Materials or Other)

Please list any past or present medical conditions:

Medical Condition	Treatment/Medications	Dosage (if applicable)	Frequency	Year

All students below the age of 18 must have their parent or legal guardian sign the following authorization in order to be eligible for treatment by the Student Health Center.

I hereby authorize the medical personnel, including the physicians and nurses of the Student Health Center and any physicians to whom they may refer any medical condition; to examine and treat (Student's name) _____ for any condition he/she may present himself/herself with at the Student Health Center while he/she is enrolled at Santa Clara University.

Signed: _____ Date: _____

Relationship to Student: ( ) Self ( ) Parent/Legal Guardian

IMMUNIZATION INFORMATION – See Other Form