UNIVERSITY OF CALIFORNIA, SAN DIEGO UCSD

BERKELEY • DAVIS • IRVINE • LOS ANGELES • MERCED • RIVERSIDE • SAN DIEGO • SAN FRANCISCO SANTA BARBARA • SANTA CRUZ

Summer Program for Incoming Students (SPIS)
Department of Computer Science & Engineering

9500 Gilman Drive MC 0404
La Jolla, California 92093-0404
Fax: 858-534-7029

Confidential Health History Form (1 of 2)

Student Name
Last_____ First_____ Gender ☐ M ☐ F DOB:_____
PRINT PRINT MM/DD/YYYY

Parent/guardian who holds insurance coverage for student: _____

☐ Private Medical Insurance ☐ Kaiser ☐ Medi-Cal ☐ None ☐ Other _____

☐ **PLEASE provide a copy of the front and back of the insurance and/or prescription card that covers the student**

GENERAL HEALTH

My general health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Height:_____ Weight:_____lbs. Eye Color:_____ Hair Color: _____

List any recent or continuing health problems: _____

List any physical or learning disabilities: _____

Are you currently under the care of a doctor or other healthcare professional? ☐ Yes ☐ No

If yes, please specify for what condition(s): _____

MEDICAL HISTORY

Please circle the appropriate answer for each of the following questions as it pertains to the SPIS student:

OVER-THE-COUNTER MEDICATIONS: Okay to dispense at students request? (i.e. Tylenol, Advil, Motrin, Pepto Bismol, etc) Restrictions_____	YES	NO	FOOD (please mark all that apply): ☐ Vegetarian ☐ Vegan ☐ Allergies Specify allergies_____ Dietary Restrictions_____	YES YES	NO NO
Allergic to any medications? If yes, medications and symptoms: _____	YES	NO	Diabetes? If yes, do you use insulin and how often? _____	YES YES	NO NO
Knee, hip, ankle, shoulder, arm or back injuries/operations? If yes, date and type of injury: _____	YES	NO	Do you carry an epinephrine pen? Bee Sting Kit? Allergic to insect bites? _____	YES YES YES	NO NO NO
Prosthetic joints or devices If yes, list_____ Other (e.g. crutches)_____	YES YES	NO NO	Respiratory problems? Asthma? Do you carry an inhaler? _____	YES YES	NO NO
Surgery/Hospitalization? List type and year: _____	YES	NO	Cultural/Religious Restrictions? Food? _____ Other? _____	YES	NO
Neurological problems? Epilepsy? Pacemaker?	YES YES YES	NO NO NO	Contact lenses or eyeglasses Hearing Aids: ☐ Both ☐ Right ☐ Left	YES YES	NO NO

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Confidential Health History Form (2 of 2)

MEDICATIONS – Student is required to store prescription and over-the-counter medications in original containers with written instructions and is responsible to administer dosage according to instructions.

ARE YOU TAKING ANY MEDICATIONS? ☐ YES ☐ NO If yes, please specify below:

_____

AUTHORIZATION FOR TREATMENT

Instructions: In the event of an emergent, staff of the Summer Program for Incoming Students (SPIS) will make every effort to reach the parent(s)/guardian(s) before using the authorization below. However, in the case of an emergency, your authorization may assist in obtaining immediate and necessary medical care for your child or dependent.

Statement: By signing this authorization, I hereby authorize the University of California's employees, faculty, agents or other designated official to act on my behalf and authorize such emergency treatment for my child/dependent to secure whatever treatment is deemed necessary.

The authority granted by this authorization includes the authority to consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care under the general or special supervision and upon the advice of or to be rendered by a physician and/or surgeon. This authority also extends to any x-ray examination, anesthetic, dental, or surgical diagnosis or treatment and hospital care by a dentist.

I understand that I am responsible for any and all charges incurred including transportation by ambulance. If I am unable to pick up my child/dependent in the event of an emergency, my child/dependent may be released to the emergency contact listed below. This authorization is valid until August 31, 2013.

Mother's Name: _____

Mother's Day phone:_____ Mother's Evening phone: _____

Father's Name: _____

Father's Day phone:_____ Father's Evening phone: _____

Emergency Contact (other than parent/guardian): _____

Day phone:_____ Evening phone: _____

AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION

I hereby authorize SPIS to release the information included on this form, including all pages of this Confidential Health History form, and any additional medical information submitted to SPIS (including verbal, electronic, and supplemental pages) or to the University of California's employees, faculty, agents or other designated official to medical and/or psychological professionals, agents or other designated personnel. I understand that this information will be used for the purpose of protecting my child's/dependent's health during the period of his/her participation in the program identified on the form, including, but not limited to providing information for the purpose of medical treatment in the case of medical urgency while participating in SPIS.

❑ **I HAVE ENCLOSED A COPY OF BOTH SIDES OF MY MEDICAL INSURANCE CARD** and understand that this information will be used for the purpose of protecting my child's/dependent's health during the period of his/her participation in the program identified on the form, including, but not limited to providing information for the purpose of medical treatment in the case of medical urgency while participating in SPIS. This authorization is valid until August 31, 2013.

_____	_____	_____
Student Name (Please Print)	Student Signature	Date
_____	_____	_____
Parent/Guardian Name (Please Print)	Parent/Guardian Signature	Date