Medical Treatment Authorization

I hereby authorize and give my consent to any licensed Health Care Provider to perform upon or administer to _____ (name of student) any reasonable necessary medical or surgical treatment. I also give permission to administer whatever anesthetic may be necessary or advisable during medical or surgical procedures. This authorization is intended to cover emergency treatment, immunizations, injections and minor operations and procedures.

This authorization does not entitle the service or physician to render any medical or surgical treatment without the student's personal consent, unless the student is unable to give consent (i.e. unconsciousness).

Permission is also granted to release information from the student's medical records when necessary for treatment of a medical condition.

This permission is good only while the student is participating in the La Sierra University sponsored activity listed as Camp La Sierra University - Summer 2026.

_____ _____

Signature of Student Date

_____ _____

Parent (or Guardian Signature, if student is under 18 years) Date

LA SIERRA UNIVERSITY

Medical History Form

Name _____ Date of Birth _____/_____/_____

Dates of Travel _____ Destination _____

School / Work Address _____ Phone (____)_____

Home Address _____ Phone (____)_____

Parent or Guardian (if under age 18) _____ Phone (____)_____

Person to notify in case of emergency _____

Daytime Phone (____)_____ Evening/ Night Phone (____)_____

Alternative person to notify in case of emergency _____

Daytime Phone (____)_____ Evening/ Night Phone (____)_____

Physician's Name _____ Hospital preference _____

PLEASE COMPLETE THE FOLLOWING:

Have you had (or do you presently have) any of the following? If you answer "yes" to any of the following questions, please describe the problem and its implications for proper first aid treatment on a separate piece of paper.

	Circle One	
Head injury (Concussion, skull fracture)	Yes	No
Fainting spells (dizziness, Unconsciousness)	Yes	No
Convulsions/epilepsy/seizures	Yes	No
Asthma or wheezing	Yes	No
High blood pressure	Yes	No
Kidney/bladder infections	Yes	No
Hernia	Yes	No
Diabetes	Yes	No
Allergies	Yes	No
Specify _____		

	Circle One	
Impaired Vision	Yes	No
Frequent eye infections	Yes	No
Persistent ear infections	Yes	No
Loss of hearing	Yes	No
Cancer or malignancy	Yes	No
Severe skin disease	Yes	No
Palpitations of the heart or arrhythmias	Yes	No
Heart murmur	Yes	No
Migraine or other headaches	Yes	No
Anemia	Yes	No
Neck or back injury	Yes	No
Other injuries _____		

Have you had a recent Tetanus Booster?_____ If so, when?____
Are you currently taking any medications? ___ If so, what?_____ Why?_____
Has the doctor place any restrictions on your activity? _____ Explain _____

_____ Date _____
Signature of Student

_____ Date _____
Signature of Parent or Guardian (if under 18 years)