



You can submit this form by uploading it as a PDF to the Health Center's Online Portal, located at





Medical Entrance Form

Student Health Services

LOCATION 200 Georgia Ave. • ADDRESS 1500 N. Patterson St. • Valdosta, GA 31698-0175
PHONE 229.333.5886 • FAX 229.249.2791 •

You can submit this form by uploading it to the Health Center's Online Portal, located at www.valdosta.edu/health or you may send the form as a PDF to immunizations@valdosta.edu. Questions can be emailed to immunizations@valdosta.edu or you may call us at 229.219.3203.

SEMESTER BEGINNING _____ DATE _____ VSU STUDENT ID NUMBER _____ DATE OF BIRTH _____ AGE AT TIME OF APPLICATION _____

NAME (LAST, FIRST, MIDDLE) _____

ADDRESS _____ CITY _____ STATE _____ COUNTRY _____

ZIP CODE _____ (_____) _____ - _____ CELL PHONE _____ EMAIL _____

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Anemia | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Migraines | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Post-traumatic Stress Disorder |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Sexually Transmitted Infections |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Prostate Trouble | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Frequent Urinary Tract Infections |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Elevated Cholesterol | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> or Other Blood Disorders |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Alcohol/Substance Abuse |
| <input type="checkbox"/> Fractures | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Problem |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Thyroid Trouble | <input type="checkbox"/> Anxiety or Panic Disorder | <input type="checkbox"/> Depression | _____ |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Venous Thrombosis | |

Do you have a living will, advanced directive, durable power of attorney for healthcare or physician order for life sustaining treatment?
(If yes, submit with your medical records forms to Student Health Services.) T YES T NO

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LOCATION 200 Georgia Ave. •

5. AUTHORIZATION TO TREAT (If you are 18 years of age or OVER)

- The General Consent for treatment gives permission to personnel of Valdosta State University Health Services to perform a medical evaluation including obtaining a history, doing a physical exam, performing a diagnostic workup and providing treatment, including minimally invasive procedures such as venipuncture to draw blood, x-rays, and IV catheter insertion to administer medications or IV uids.
- The patient has the right to refuse any treatment.
- A record of General Consent for Treatment will be stored in the patient's medical record.
- Duration of General Consent for Treatment has continuing force and effect until the patient revokes the consent.

I hereby authorize the physicians, physician assistants, and nurse practitioners of Valdosta State University Health Services and their agents or consultants, including those at area hospitals and/or Georgia Department of Public Health, to perform diagnostic and treatment procedures which in their judgment may be necessary while I am at Valdosta State University. I understand I am responsible for charges incurred.

_____/_____/_____
PATIENT SIGNATURE DATE

6. AUTHORIZATION TO TREAT (If you are UNDER 18 years of age)

I hereby authorize the physicians, physician assistants, and nurse practitioners of Valdosta State University Health Services, and their agents or consultants, including those at area hospitals and/or Georgia Department of Public Health, to perform diagnostic and treatment procedures which in their judgment may be necessary while he/she attends Valdosta State University. I waive all claim to prior noti cation. I understand that every reasonable effort will be made to notify me in the event of a major illness or injury, or if the Valdosta State University Health Services physician feels it is necessary. I understand I am responsible for charges incurred.

_____/_____/_____
PATIENT SIGNATURE DATE

_____/_____/_____
SIGNATURE OF PARENT/GUARDIAN DATE

EMERGENCY CONTACT INFORMATION

NAME RELATIONSHIP

ADDRESS

CITY STATE COUNTRY ZIP CODE

(_____)_____-_____(_____)_____-_____
DAYTIME PHONE EVENING PHONE EMAIL

NAME RELATIONSHIP

ADDRESS

CITY STATE COUNTRY ZIP CODE

(_____)_____-_____(_____)_____-_____
DAYTIME PHONE EVENING PHONE EMAIL

PLEASE NOTE: RETURN THESE FORMS TO STUDENT HEALTH SERVICES PRIOR TO YOUR ORIENTATION DATE.

Students should keep a copy of these forms for their personal records.

NAME VSU STUDENT ID NUMBER

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NAME

STUDENT ID NUMBER

ADDRESS

[Redacted]

[Redacted]

[Redacted]

