[redacted]

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

[redacted]

[redacted]

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 _____

T Emphysema
T Tuberculosis
T Pneumonia
T Bronchitis
T Allergies
T Diabetes
T Cirrhosis
T Fractures
T Arthritis
T Thyroid Trouble
T Cardiovascular Disease

T Anemia
T Migraines
T Heart Disease
T Prostate Trouble
T Elevated Cholesterol
T Stroke
T Hepatitis A
T Osteoporosis
T Ulcerative Colitis
T Anxiety or Panic Disorder
T Asthma

T Hepatitis B
T Crohn's Disease
T Sickle Cell Disease
T Irritable Bowel Syndrome
T Ulcers
T Hepatitis C
T Cystic Fibrosis
T Gallbladder Disease
T Cancer
T Depression
T Venous Thrombosis

T High Blood Pressure
T Post-traumatic Stress Disorder
T Sexually Transmitted Infections
T Frequent Urinary Tract Infections
T Bleeding Disorder or Other Blood Disorders
T Alcohol/Substance Abuse Problem
T Other: _____
_____

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

Medical Entrance Form

Student Health Services
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