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 • **WEB** www.valdosta.edu/health

ALL FORMS MUST BE COMPLETED IN ENGLISH

Date
_____/_____/_____

ACCEPTED TERM/YEAR
_____/_____

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

****This information will remain confidential and will be utilized by Student Health Services personnel only.***

1. ALLERGIES (List all medication, food, insect or other known allergies below)

Do you receive allergy shots? ❑ YES ❑ NO If yes, please have your allergy records faxed to 229.249.2791 .

2. HOSPITALIZATION (List all prior hospitalizations, surgeries, and procedures)

3. MEDICATION (List all medications including doses that you are currently taking)

4. MEDICAL HISTORY

Are you now or have you been under the care of a physician for an ongoing illness/medical condition? ❑ **YES** ❑ **NO**
Do you have a chronic (long-lasting or persistent) medical condition that requires treatment or medication? ❑ **YES** ❑ **NO**
If yes, please have your physician fax a summary of your treatment to **229.249.2791** that includes the following:

- Condition being treated
- Type of medicine
- Physician's name, address and phone number

Please check all that apply

❑ Emphysema
❑ Tuberculosis
❑ Pneumonia
❑ Bronchitis
❑ Allergies
❑ Diabetes
❑ Cirrhosis
❑ Fractures
❑ Arthritis
❑ Thyroid Trouble
❑ Cardiovascular Disease
❑ Anemia
❑ Migraines
❑ Heart Disease
❑ Prostate Trouble
❑ Elevated Cholesterol
❑ Stroke
❑ Hepatitis A
❑ Osteoporosis
❑ Ulcerative Colitis
❑ Anxiety or Panic Disorder
❑ Asthma
❑ Hepatitis B
❑ Crohn's Disease
❑ Sickle Cell Disease
❑ Irritable Bowel Syndrome
❑ Ulcers
❑ Hepatitis C
❑ Cystic Fibrosis
❑ Gallbladder Disease
❑ Cancer
❑ Depression
❑ Venous Thrombosis
❑ High Blood Pressure
❑ Post-traumatic Stress Disorder
❑ Sexually Transmitted Infections
❑ Frequent Urinary Tract Infections
❑ Bleeding Disorder or Other Blood Disorders
❑ Alcohol/Substance Abuse Problem
❑ 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.) ❑ **YES** ❑ **NO**

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_____/_____

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 fluids.
- 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 notification. 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