

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

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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 _____ (_____) _____ - _____ EMAIL _____

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

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NAME	STUDENT ID NUMBER
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ADDRESS

[Redacted text]

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[Redacted text]