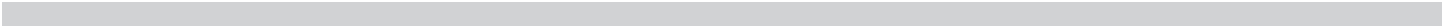




You can submit this form by uploading it as a PDF to the Health Center's Online Portal, located at





# 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](http://www.valdosta.edu/health) or you may send the form as a PDF to [immunizations@valdosta.edu](mailto:immunizations@valdosta.edu). Questions can be emailed to [immunizations@valdosta.edu](mailto: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 \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

- |   |  |   |  |
|---|--|---|--|
| <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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NAME

STUDENT ID NUMBER

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ADDRESS

[Redacted]

[Redacted]

[Redacted]

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