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



SEMESTER BEGINNING

Medical Entrance Form

Student Health Services

DATE

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.

VSU STUDENT ID NUMBER DATE OF BIRTH

ADDRESS		CITY	STATE	COUNTRY
	() –			
ZIP CODE	CELL PHONE	E N	MAIL	
T Emphysema	T Anemia		T Hepatitis B	T High Blood Pressure
T Tuberculosis	T Migraines		T Crohn's Disease	T Post-traumatic Stress Disorder
T Pneumonia	T Heart Disease		T Sickle Cell Disease	T Sexually Transmitted Infections
T Bronchitis	T Prostate Trouble	e	T Irritable Bowel Syndrome	T Frequent Urinary Tract Infections
T Allergies	T Elevated Chole		T Ulcers	T Bleeding Disorder
T Diabetes	T Stroke	-	T Hepatitis C	or Other Blood Disorders
T Cirrhosis	T Hepatitis A		T Cystic Fibrosis	T Alcohol/Substance Abuse
T Fractures	T Osteoporosis		T Gallbladder Disease	Problem
T Arthritis	T Ulcerative Coliti	S	T Cancer	T Other:
T Thyroid Trouble	T Anxiety or Panie		T Depression	
T Cardiovascular Disease	T Asthma		T 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

AGE AT TIME OF APPLICATION

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 ha	s continuing force and effect until t	he patient revokes the con	sent.
I hereby authorize the physicians, physician as agents or consultants, including those at area treatment procedures which in their judgment for charges incurred.	hospitals and/or Georgia Departm	ent of Public Health, to per	rform diagnostic and
			1
PATIENT SIGNATURE			DATE
6. AUTHORIZATION TO TREAT (If you are UNI	DER 18 years of age)		
I hereby authorize the physicians, physician assi	stants, and nurse practitioners of V	aldosta State University He	ealth Services, and their
agents or consultants, including those at area he	ospitals and/or Georgia Departmer	t of Public Health, to perfo	rm diagnostic and treatmen
procedures which in their judgment may be nec	essary while he/she attends Valdos	ta State University. I waive	all claim to prior noti cation
I understand that every reasonable effort will be	-		the Valdosta State
University Health Services physician feels it is no	ecessary. I understand I am respons	sible for charges incurred.	
			1
PATIENT SIGNATURE		DATE	_ ′ ′
CIONATURE OF PARENT/CHARRIAN			_//
SIGNATURE OF PARENT/GUARDIAN		DATE	
EN	MERGENCY CONTACT INFORM	ATION	
NAME		RELATIONSHIP	
ADDDESS			
ADDRESS			
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ADDRESS			
CITY	STATE	COUNTRY	ZIP CODE
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DI FACE NOTE, DETUDNITHESE FORMS TO	O CTUDENT HEALTH CEDVICE	C DDIOD TO VOLID ODI	ENITATION DATE
PLEASE NOTE: RETURN THESE FORMS TO		S PRIOR TO YOUR ORI	ENTATION DATE.
Students should keep a copy of these forms to	for their personal records.		
NAME		VSU STUDENT ID NUN	// BER

229.219.3203.		
NAME	STUDENT ID NUMBER	
ADDRESS		

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