



Medical Entrance Form

Student Health Services

LOCATION 200 Georgia Ave. • ADDRESS 1500 N. Patterson St. • Valdosta, GA 31698-0175
 PHONE 229.333.5886 • FAX

Date		
____	____	____

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 _____

- | | | | |
|---|--|---|--|
| <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 | 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 | 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.) **YES NO**

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



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.

NAME

STUDENT ID NUMBER

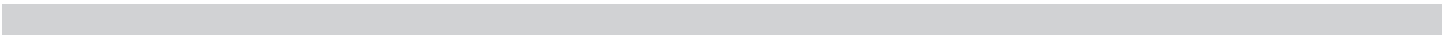
ADDRESS

DATE OF BIRTH

AGE

PHONE

TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE (REQUIRED)



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.

NAME

STUDENT ID NUMBER

ADDRESS

DATE OF BIRTH

AGE

PHONE

