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 _____ CELL PHONE (_____) _____ – _____ EMAIL _____

T Emphysema
T Tuberculosis
T Pneumonia
T Bronchitis
T Allergies
T Diabetes
T Cirrhosis
T Fractures
T Arthritis
T Thyroid Trouble
T Cardiovascular Disease

T Anemia
T Migraines
T Heart Disease
T Prostate Trouble
T Elevated Cholesterol
T Stroke
T Hepatitis A
T Osteoporosis
T Ulcerative Colitis
T Anxiety or Panic Disorder
T Asthma

T Hepatitis B
T Crohn's Disease
T Sickle Cell Disease
T Irritable Bowel Syndrome
T Ulcers
T Hepatitis C
T Cystic Fibrosis
T Gallbladder Disease
T Cancer
T Depression
T Venous Thrombosis

T High Blood Pressure
T Post-traumatic Stress Disorder
T Sexually Transmitted Infections
T Frequent Urinary Tract Infections
T Bleeding Disorder or Other Blood Disorders
T Alcohol/Substance Abuse Problem
T 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.) T YES T 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

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NAME STUDENT ID NUMBER

ADDRESS

DATE OF BIRTH AGE PHONE

TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE (REQUIRED)

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NAME STUDENT ID NUMBER

ADDRESS

DATE OF BIRTH AGE PHONE