



MEDICAL ENTRANCE

STUDENT HEALTH SERVICES

Please return this form to:
Medical Records
Student Health Services
Georgia Institute of Technology
Atlanta, GA 30332-0470

Name (LAST) (FIRST) (MIDDLE)

Date of Birth Country of Birth

GT ID# Male Female

Permanent (Home Country) Address, E-mail, and Phone Number

Street Address

City/State/Country/ZIP

Telephone Number Semester/Year of Enrollment

Home E-mail (if any)

CONTACT INFORMATION TO BE COMPLETED AT STUDENT HEALTH SERVICES

Local Address

Phone Number E-mail (if any)

The following information is strictly for the purpose of assisting Student Health Services in caring for you while you are attending Georgia Tech. It is not used as a criterion for admission and will not be released to anyone without your written consent.

- 1. ALLERGIES No Yes If yes, please give specific details.
Drugs
Pollen
Food
Insect
Other

- 2. HOSPITALIZATION Have you ever been hospitalized?
If yes, please give 1) Date of hospitalization month/day/year
2) Reason for hospitalization

- 3. MEDICATION Are you currently taking medication?
If yes, please list the medication(s)

4. MEDICAL CONDITION

Do you have a chronic (long-lasting or persistent) medical condition that requires treatment or medication? Yes No

If yes, please have your physician send a summary of your treatment that includes the following:

- Condition being treated
- Type of medication
- Physician's address and phone number

5. AUTHORIZATION TO TREAT *If you are over 18 years of age*

I hereby authorize the physicians of Student Health Services and their agents or consultants, including those at area hospitals, to perform diagnostic and treatment procedures which in their judgment may become necessary while I am at Georgia Tech.

Signature _____ Date _____

AUTHORIZATION TO TREAT *If you are under 18 years of age*

I hereby authorize the physicians of Student Health Services and their agents or consultants, including those at area hospitals, to perform diagnostic and treatment procedures on the above named student which in their judgment may become necessary while she/he attends Georgia Tech. I waive all claim to prior notification. I understand that every effort will be made to notify me in the event of a major illness or injury, or if the Student Health Services physician feels it is necessary.

Signature of parent/guardian _____ Date _____

6. PERSON(S) TO CONTACT IN THE EVENT OF AN EMERGENCY

Name _____ Relationship _____

Address _____

Daytime Phone (_____) _____ Nighttime Phone (_____) _____

E-mail Address (if any) _____

Name _____ Relationship _____

Address _____

Daytime Phone (_____) _____ Nighttime Phone (_____) _____

E-mail Address (if any) _____

7. MEDICAL INSURANCE INFORMATION

Insurance Company Name and Address _____

Policy No. _____

Group No. _____

Identification No. _____

GEORGIA TECH STUDENT HEALTH SERVICES

PHONE: 404.894.1432 or 404.894.0587

FAX: 404.385.0329, 404.894.0626, or 404.894.7480

WEB: www.health.gatech.edu

FORM A