East Georgia STATE COLLEGE™

MEDICAL ENTRANCE FORM
REQUIRED

Student ID #: _____-_____-_____

Name: (Last) _____(First)_____(Middle)_____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Term/Year of Application: _____ Age at time of application: _____ Date of Birth: _____/_____/_____

The following information is strictly for the purpose of assisting Student Health Services in caring for you while you are attending East Georgia State College. It is not used as a criterion for admission and will not be released to anyone without your written consent. The staff of Student Health Services will share information only if you have contacted them for assistance.

1. ALLERGIES

Drug	O YES O NO	If yes, please give specific details:_____
Pollen	O YES O NO	If yes, please give specific details:_____
Food	O YES O NO	If yes, please give specific details:_____
Insect	O YES O NO	If yes, please give specific details:_____
Other	O YES O NO	If yes, please give specific details:_____

2. HOSPITALIZATIONS

Have you ever been hospitalized? O YES O NO

If yes, please give: Date of hospitalization (MM/DD/YY) _____

Reason for hospitalization

3. MEDICATION

Are you currently taking medication? O YES O NO

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? O YES O NO

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

- Condition being treated
- Type of Medicine
- 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 East Georgia State College.

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 East Georgia State College. I waive all claims 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. EMERGENCY CONTACT(S)

Name: _____ Relationship _____

Address (Street, City, State) _____

Daytime Phone _____ Nighttime Phone _____

Email Address _____

Name: _____ Relationship _____

Address (Street, City, State) _____

Daytime Phone _____ Nighttime Phone _____

Email Address _____

7. MEDICAL INSURANCE INFORMATION ***(if applicable)***

Insurance Company Name: _____

Address (Street, City, State) _____

Policy Number _____

Group Number _____

Identification Number _____