Georgia Tech Stamps Health Services
Campus Services

MEDICAL ENTRANCE FORM (REQUIRED)

UNDER 18 YEARS OF AGE ONLY

(If over 18, continue to page 2)

Please upload completed form at www.immunizations.health.gatech.edu

RETAIN A COPY OF THE COMPLETED FORM FOR YOUR RECORDS

Semester Beginning: _____

GT ID#: _____ Cell Phone #: _____ Email: _____

Name (Last, First, Middle) _____

Address: _____ City: _____ State: _____ Country: _____

Zip Code: _____ Birth Date: _____

AUTHORIZATION TO TREAT

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

Signature of parent/guardian: _____ **Date:** _____

Print Name: _____ **Relationship:** _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Country: _____ Zip Code: _____

Daytime phone: _____ Evening phone: _____ Email: _____

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Country: _____ Zip Code: _____

Daytime phone: _____ Evening phone: _____ Email: _____