

**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](http://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: \_\_\_\_\_