

Language Institute • Georgia Institute of Technology • Atlanta, GA 30332-0374, USA

TELEPHONE NUMBER: 404-894-2425 FAX NUMBER: 404-894-8755

WEB SITE: <http://www.esl.gatech.edu/>

**Please return this completed form WITH your physician-completed Certificate of MMR Immunization to:**

Language Institute  
Georgia Institute of Technology  
Atlanta, GA 30332-0374

**NAME:** \_\_\_\_\_  
LAST NAME FIRST NAME MIDDLE NAME

**DATE OF BIRTH:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **COUNTRY OF BIRTH:** \_\_\_\_\_  
Month / Day / Year

**MALE** \_\_\_\_ **FEMALE** \_\_\_\_

**SESSION OF APPLICATION:**

\_\_ Fall 1 20\_\_      \_\_ Spring 1 20\_\_      \_\_ Summer 20\_\_  
 \_\_ Fall 2 20\_\_      \_\_ Spring 2 20\_\_

**PERMANENT (HOME COUNTRY) ADDRESS:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

The following information is strictly for the purpose of assisting the Student Health Center 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**

Drug	___	___	_____
Pollen	___	___	_____
Food	___	___	_____
Insect	___	___	_____
Other	___	___	_____

2. **HOSPITALIZATION:**  
 Have you ever been hospitalized?      \_\_\_ YES      \_\_\_ NO  
**If yes, please give**

1) Name of hospital	_____
2) Date of hospitalization	_____
3) Reason for hospitalization	_____

3. **MEDICATION:**  
 Are you currently taking medication?      \_\_\_ YES      \_\_\_ NO  
**If yes, please list the medication(s):**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(Go to: [www.health.gatech.edu](http://www.health.gatech.edu) for more information on Georgia Tech's Health Center)

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 to include the following:

- condition being treated
- type of medication
- physician's address, phone number, & fax number

5. If you are over 18 years of age

**AUTHORIZATION TO TREAT:** I hereby authorize the physicians of the Student Health Center and their agents or consultants, including those at area hospitals, to perform diagnostic and treatment procedures which in their judgement may become necessary while I am at Georgia Tech.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

If you are under 18 years of age

**AUTHORIZATION TO TREAT:** I hereby authorize the physicians of the Student Health Center and their agents or consultants, including those at area hospitals, to perform diagnostic and treatment procedures, on the above named student, which in their judgement may become necessary while he/she 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 Service 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: ( ) \_\_\_\_\_

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DAYTIME PHONE: ( ) \_\_\_\_\_ NIGHTTIME PHONE: ( ) \_\_\_\_\_

7. **MEDICAL INSURANCE INFORMATION:**

Insurance Company Name & Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Identification # \_\_\_\_\_

**Do not write below this line**

To be completed at the Student Health Center

Local Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_