Georgia Tech Stamps Health Services
Campus Services

MEDICAL ENTRANCE FORM

REQUIRED FOR STUDENTS UNDER 18 YEARS OF AGE

(Retain a copy of the completed form for your records)

Semester Beginning: _____

Today's Date: _____ GT ID#: _____ Birth Date: _____ Age at time of Application: _____

Name (Last, First, Middle): _____

Address: _____

Zip Code: _____ Cell Phone #: _____ Email: _____

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: _____

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: _____
