Valdosta State University
Student Health Center
200 Georgia Avenue
Valdosta, GA 31698
229.333.5886
www.valdosta.edu/health

Today's Date: _____ VSU ID #: 870_____

PATIENT INFORMATION

Patient Name: _____ Birthdate: ____/____/____ Age*: _____
Last First MI

*for students under 18 years of age, a parental or legal guardian authorization for medical treatment form must be on file in our office in order for you to receive prompt care and treatment should the need arise.

Sex: Male Female Other Marital Status: Single Married Divorced

Race: Asian Black Multiracial White Hispanic American Indian/Alaskan Native Hawaiian/Pacific Islander

Permanent Home Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Cell: _____ Home Phone: _____ Email: _____

Local Address or Residential Hall – Room # & VSU Box #: _____

City: _____ State: _____ Zip Code: _____

CONTACT INFORMATION

Emergency Contact: _____ Relationship to you: _____

Home Phone: _____ Cell: _____Mother's Maiden Name: _____

Consent to Treatment: I voluntarily authorize the rendering of such care, including diagnostic and medical treatment by authorized agents and employees of Valdosta State University Student Health Center (hereafter referred to as Student Health) and the medical staff, or their designees, as