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