



MEDICAL ENTRANCE
STUDENT HEALTH SERVICES

Please return this form to:

Medical Records
Student Health Services
Georgia Institute of Technology
Atlanta, GA 30332-0470

Name _____
(LAST) (FIRST) (MIDDLE)

Date of Birth _____ Country of Birth _____

GT ID# _____ Male Female

Permanent (Home Country) Address, E-mail, and Phone Number

Street Address _____

City/State/Country/ZIP _____

Telephone Number (_____) _____ Semester/Year of Enrollment _____

Home E-mail (if any) _____

CONTACT INFORMATION

TO BE COMPLETED AT STUDENT HEALTH SERVICES

Local Address _____

Phone Number (_____) _____ E-mail (if any) _____

The following information is strictly for the purpose of assisting Student Health Services 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. The staff of the Counseling Center and Student Health Services will share information only if you have contacted both agencies for assistance.

- 1. ALLERGIES**
- | | No | Yes | If yes, please give specific details. |
|--------|-----------------------|-----------------------|--|
| Drugs | <input type="radio"/> | <input type="radio"/> | _____ |
| Pollen | <input type="radio"/> | <input type="radio"/> | _____ |
| Food | <input type="radio"/> | <input type="radio"/> | _____ |
| Insect | <input type="radio"/> | <input type="radio"/> | _____ |
| Other | <input type="radio"/> | <input type="radio"/> | _____ |

- 2. HOSPITALIZATION**
- Have you ever been hospitalized? Yes No
- If yes, please give
- 1) Date of hospitalization _____
month/day/year
- 2) Reason for hospitalization _____

- 3. MEDICATION**
- Are you currently taking medication? Yes No
- If yes, please list the medication(s) _____
- _____

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 that includes the following:

- Condition being treated
- Type of medication
- Physician's address and phone number

5. AUTHORIZATION TO TREAT *If you are **over 18 years of age***

I hereby authorize the physicians of Student Health Services and their agents or consultants, including those at area hospitals, to perform diagnostic and treatment procedures which in their judgment may become necessary while I am at Georgia Tech.

Signature _____ **Date** _____

AUTHORIZATION TO TREAT *If you are **under 18 years of age***

I hereby authorize the physicians of Student Health Services and their agents or consultants, including those at area hospitals, to perform diagnostic and treatment procedures on the above named student which in their judgment may become necessary while she/he 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 Services 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 (_____) _____

E-mail Address (if any) _____

Name _____ Relationship _____

Address _____

Daytime Phone (_____) _____ Nighttime Phone (_____) _____

E-mail Address (if any) _____

7. MEDICAL INSURANCE INFORMATION

Insurance Company Name and Address _____

Policy No. _____

Group No. _____

Identification No. _____

GEORGIA TECH STUDENT HEALTH SERVICES

PHONE: 404.894.1432 or 404.894.0587
WEB: www.health.gatech.edu

FAX: 404.385.0329, 404.894.0626, or 404.894.7480
E-MAIL: imm@health.gatech.edu

FORM A



CERTIFICATE OF IMMUNIZATION

STUDENT HEALTH SERVICES

Note: Keep a copy of this document for your records.

PART I (to be completed by the student)

Georgia Tech ID# _____ Date of Birth _____
MONTH/DAY/YR

Name _____
LAST FIRST MIDDLE

Address _____
STREET CITY STATE ZIP

Home Country _____

PART II (to be completed and signed by your health care provider)

REQUIRED IMMUNIZATIONS:

A. Measles, Mumps, and Rubella (required for students born in 1957 or later). Health care provider must select item 1, 2, or 3 below, and complete.

1. MMR (Measles, Mumps, and Rubella)

2 doses with the first dose at 12 months or later _____ and the second dose at least 28 days after the
MONTH/DAY/YR
 first dose _____ **OR** Laboratory/serologic evidence of immunity
MONTH/DAY/YR

2. Individual immunizations:

a. Measles: 2 doses with the first dose at 12 months or later _____ and the second dose at least 28 days after the
MONTH/DAY/YR
 first dose _____ **OR** Laboratory/serologic evidence of immunity
MONTH/DAY/YR

b. Mumps: 1 dose at 12 months or later **OR** Laboratory/serologic evidence of immunity

c. Rubella: 1 dose at 12 months or later **OR** Laboratory/serologic evidence of immunity

3. Exemption: Student was born before 1957 and therefore is exempt.

B. Tetanus/Diphtheria (Td booster in the last 10 years or primary series with DTaP, DTP, or Td).

1 Td booster dose within the last 10 years prior to matriculation _____
MONTH/DAY/YR

Completion of primary series (DTaP, DTP, or Td) within the last 10 years prior to matriculation _____
MONTH/DAY/YR

C. Varicella (either a history of chicken pox, a positive Varicella antibody, or 2 doses of vaccine given at least 1 month apart if immunized after age 13)

History of disease **OR** Laboratory/serologic evidence of immunity **OR** 1 dose given at 12 months of age or later but before the student's 13th birthday **OR** 2 doses (dose 1 given after the student's 13th birthday, dose 2 given at least one month after dose 1)

D. Hepatitis B (3 doses of vaccine or a positive Hepatitis surface antibody)

3 doses of Hepatitis B _____ **OR**
MONTH/DAY/YR MONTH/DAY/YR MONTH/DAY/YR

3 doses combined HepA/HepB series _____ **OR**
MONTH/DAY/YR MONTH/DAY/YR MONTH/DAY/YR

2 doses Hepatitis B series of Recombivax _____ **OR**
MONTH/DAY/YR MONTH/DAY/YR

Laboratory/serologic evidence of immunity or prior infection

E. Other Immunizations: _____

F. Exemption:

This student is exempt from the above immunization(s) on grounds of permanent medical contraindication.

This student is temporarily exempt from the above immunizations until _____
MONTH/DAY/YR

Health care provider Name _____ Date _____

Address _____ Phone () _____

Signature _____

TUBERCULOSIS SCREENING

Name _____ GT ID# _____

THIS FORM MUST BE COMPLETED AND RETURNED TO HEALTH SERVICES BEFORE REGISTERING FOR CLASSES.

Georgia Institute of Technology guidelines for tuberculosis screening are based on the recommendations of the U.S. Centers for Disease Control and Prevention, the American Thoracic Society, and the American College Health Association. Screening must be completed within one year before the first day of class.

1. Does the student have signs or symptoms of active tuberculosis? Yes No
- If No, proceed to question 2.
 - If Yes, proceed with additional evaluation to exclude active tuberculosis, including Mantoux skin test, chest x-ray, sputum evaluation, and medication as indicated.

2. Is the student a member of a high-risk group ** (see below)? Yes No
- If No, stop. No further evaluation is needed at this time.
 - If Yes, and the student has not had a previous positive tuberculin skin test, proceed to 3 and place tuberculin skin test (Mantoux only: Inject 0.1 ml of purified protein derivative (PPD) tuberculin containing 5 tuberculin units (TU) intradermally into the volar (inner) surface of the forearm. A history of BCG vaccination should not preclude testing of a member of a high-risk group). The test must be performed in the United States. If the student has a history of positive tuberculin skin test, proceed to 4.

3. **Tuberculin Skin Test:**

Date placed ____/____/____ Date read ____/____/____ (must be within 48 - 72 hours)
 Result _____ (Record actual mm of induration, transverse diameter. If no induration, record as "0 mm.")
 Interpretation: (based on mm of induration as well as risk factors) POSITIVE NEGATIVE

4. **Chest X-Ray:** (Required if PPD skin test is positive or student has a history of previous positive tuberculin skin test.)

Date of chest x-ray ____/____/____ Result: NORMAL ABNORMAL - Abnormal must include copy of the chest x-ray report in English and signed by a physician.

Treatment:

- Type of treatment with anti-tubercular drugs: _____
- Length of treatment _____
- Treatment declined

Verification of the above Tuberculosis Screening by Healthcare Provider (This line MUST be signed.)

Verified by _____ () _____
 PRINT NAME/TITLE ADDRESS PHONE

Signature _____

** Categories of high-risk students include those who have arrived within the past five years from countries where TB is endemic. It is easier to identify countries of low, rather than high, TB prevalence; therefore, students should undergo TB screening EXCEPT those from the following countries: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia, USA, Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, or New Zealand. Other categories of high-risk students include those with HIV infection; those who inject drugs; those who have resided in, volunteered in, or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastroectomy and jejunioleal bypass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone 15 mg/d for one month), or other immunosuppressive disorders.

International students: If your local physician cannot verify tuberculosis screening as described above, this form must be completed by a physician in the United States. See www.health.gatech.edu for more information.

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