FORM A

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	○	○	______________________
Pollen	○	○	______________________
Food	○	○	______________________
Insect	○	○	______________________
Other	○	○	______________________

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) ____

____

OVER

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. ______________________

FORM B

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 _____/______/______ (MONTH/DAY/YR) and the second dose at least 28 days after the first dose _____/______/______ (MONTH/DAY/YR) **OR** ☐ Laboratory/serologic evidence of immunity

2. **Individual immunizations:**

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

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 _____/______/______ (MONTH/DAY/YR) _____/______/______ (MONTH/DAY/YR) _____/______/______ (MONTH/DAY/YR) **OR**
☐ 3 doses combined HepA/HepB series _____/______/______ (MONTH/DAY/YR) _____/______/______ (MONTH/DAY/YR) _____/______/______ (MONTH/DAY/YR) **OR**
☐ 2 doses Hepatitis B series of Recombivax _____/______/______ (MONTH/DAY/YR) _____/______/______ (MONTH/DAY/YR) **OR**
☐ 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 ______________________

OVER **FORM B**

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, Licchtenstein, 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 jejunoileal 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.

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