Student Name (Printed) _____ _____ _____

Last First MI FSU SN or FSU ID Date of Birth

THE FLORIDA STATE UNIVERSITY
UNIVERSITY HEALTH SERVICES
HEALTH & WELLNESS CENTER

University Health Services
Florida State University
960 Learning Way
Tallahassee, FL 32306-4178
(850) 644-3608
Fax: (850) 644-8958

PART A – To be completed by Clinician/Records Custodian

REQUIRED

BOTH IMMUNIZATIONS MUST BE COMBINED MMRs. SINGLE SHOTS ACCEPTED ONLY IF ADMINISTERED ON THE SAME DATE.

MMR	Dose 1____/___/_____ Month Day Year	Dose 2____/___/_____ Month Day Year	
Meningococcal meningitis Vaccine If not provided, student must sign required waiver below.	Dose 1____/___/_____ Month Day Year	Dose 2____/___/_____ Month Day Year	
Hepatitis B If not provided, student must sign required waiver below.	Dose 1____/___/_____ Month Day Year	Dose 2____/___/_____ Month Day Year	Dose 3____/___/_____ Month Day Year

RECOMMENDED

Polio	Dose 1____/___/_____ Month Day Year	**Td (most recent booster)**	____/___/_____ Month Day Year
TB skin test (PPD) **Mm ___ Pos ____ Neg ____** **If positive, provide documentation of treatment type and dates.**	____/___/_____ Month Day Year	**Tdap (most recent booster)**	____/___/_____ Month Day Year
Chicken Pox (varicella) Or date of disease: ____/___/_____ Month Day Year	Dose 1____/___/_____ Month Day Year Dose 2____/___/_____ Month Day Year Titer ____/___/_____ Month Day Year	**Gardasil**	Dose 1____/___/_____ Month Day Year Dose 2____/___/_____ Month Day Year Dose 3 ____/___/_____ Month Day Year
Hepatitis A	Dose 1____/___/_____ Month Day Year Dose 2____/___/_____ Month Day Year	**Pneumococcal Vaccine (as indicated)**	____/___/_____ Month Day Year

Attach additional physician comments regarding any history of prior vaccine allergic reactions, medical contraindications, etc:

AUTHORIZED CLINICIAN SIGNATURE: My signature verifies, as of this date, all entries documented. The form must be signed by the person who entered the information.

_____ _____ _____ _____

TYPED OR PRINTED NAME AUTHORIZED SIGNATURE DATE OFFICE STAMP WITH OFFICE ADDRESS & fax #

Immunizations given after the form has been signed must be separately documented on a separate sheet of paper, including authorized signature and office stamp with office address and fax. Use of a prescription pad is sufficient.

Part B - Must Be Completed By Student

STUDENT SIGNATURE REQUIRED REGARDLESS OF AGE. I HAVE READ AND UNDERSTAND THE IMMUNIZATION REQUIREMENTS ON THIS FORM. This form has been truthfully completed to the best of my knowledge and I freely consent to this form being used for my treatment at University Health Services and for my registration here or at any other university.

Signature_____ Today's Date_____

Meningococcal meningitis and Hepatitis B – Waiver must be completed **only** if dates of vaccines are not provided above.

I have received the required information regarding the risks of acquiring meningococcal meningitis and Hepatitis B and the benefits of receiving immunizations to reduce those risks. I also understand that I am required to receive these immunizations or to actively decline the immunizations. I understand that declining these vaccines now does not mean I may not receive them in the future.

_____ I decline receiving the meningococcal meningitis vaccine. _____ I decline receiving the hepatitis B vaccine

Initials Initial