THE FLORIDA STATE UNIVERSITY

UNIVERSITY HEALTH SERVICES

HEALTH & WELLNESS CENTER

Part A—Print or type. Illegible forms will not be processed.

STUDENT NAME: _____

DATE OF BIRTH: ____/___/_____ FSU EMPLID _____ Gender: ◯Male ◯Female◯Other Race: _____

Home Phone: _____ Cell Phone: _____ E-mail: _____

Part B **Dates Required**	**REQUIRED IMMUNIZATIONS**		
Combined MMR dates No single shots	Dose 1 / / On or after first birthday	Dose 2 / / At least 28 days later	Titers: document attached
Meningococcal Meningitis dates	Dose 1 / /	Dose 2, if applicable	
Meningococcal Meningitis	Waiver ☐ Student Initials _____	Date / / of waiver (REQUIRED)	
Hepatitis B dates	Dose 1 / /	Dose 2 / /	Dose 3 / /
Hepatitis B	Waiver ☐ Student Initials_____	Date / / of waiver (REQUIRED)	Titer: document attached

Waiver Information: 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 by placing my initials in the space(s) **provided above**. I understand that I may decline either or both immunizations and that declining these vaccines now does not mean I may not receive them in the future. _____

patient signature

Part C: AUTHORIZATION and additional comments: The immunization dates and any statements of contraindication to immunizations entered on this document are, as of the date signed, verified by my signature below. Additional physician comments: _____

_____

Clinician or Records Custodian Name

_____ _____

Clinician or Records Custodian Signature Date Office Stamp

Please list any relevant personal and family medical history. _____

Do you have any allergies (including medications): ☐ No ☐ Yes Please List if yes:_____

REQUIRED AUTHORIZATION FOR CARE FOR STUDENTS UNDER THE AGE 18: I concur with the above and authorize, at the discretion of health center personnel, medical and surgical care including examinations, treatments, immunizations and the like for my son/daughter. In the event of serious disease or injury or the need for major surgery, I understand that all reasonable efforts will be made to contact me but the failure to make contact will not prevent emergency treatment if necessary to preserve life or health Signature: _____ Date:_____

FSU Health Compliance Record fax to 850-644-8958 or mail to 960 Learning Way, Tallahassee, FL 32306-4178

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Print or type. Illegible forms will not be processed.

STUDENT NAME: _____ Email: _____

DATE OF BIRTH: ____/___/_____ FSU EMPLID_____ Gender: ◯M ◯F ◯Other

Home Phone: _____ Cell Phone: _____ Race: _____

Part B: OPTIONAL IMMUNIZATIONS

Polio	/ /	**Tdap (Most recent booster)** **Athletes must show proof**	/ /
TB skin test (PPD)	/ /	**Td (Most recent booster)**	/ /
Chicken Pox (varicella)	Dose 1 / / Dose 2 / / Titer / /	**Gardasil**	Dose 1 / / Dose 2 / / Dose 3 / /
Hepatitis A	Dose 1 / / Dose 2 / /	**Pneumococcal Vaccine**	/ /

Part C: AUTHORIZATION and additional comments: My signature verifies, as of this date, all immunization entries made on this document and any statements of contraindication to immunization made hereon. Attached documents must be separately authorized. Additional physician comments: _____

_____
Clinician or Records Custodian Name

_____ _____
Clinician or Records Custodian Signature Date Office Stamp

INSURANCE REQUIREMENT: Optional to clear compliance (Go to Student insurance.fsu.edu)

Last (Primary):_____ First:_____ Middle Initial: _____

Relationship: (to student)_____ Primary's DOB:_____ Primary's Gender:_____

Policy No:_____ Group No:_____

Effective Date: (mm/dd/yyyy) _____ Termination Date: (mm/dd/yyyy) _____

Insurance Company:_____ Customer Service Ph #:_____

Claims Mailing Address: _____

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