FLORIDA STATE UNIVERSITY

UNIVERSITY HEALTH SERVICES

HEALTH & WELLNESS CENTER

Part A– Print or type. Illegible form will not be processed

LAST NAME: _____ FIRST NAME: _____ DOB: _____

EMPLID_____ EMAIL_____ PRIMARY PHONE#_____

Please list any relevant personal and family medical history. _____

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

REQUIRED AUTHORIZATIONS FOR CARE FOR STUDENTS UNDER THE AGE OF 18: I authorize health center personnel, medical and surgical care including examinations, treatment, immunizations and the like for my son/daughter. In the event of serious disease or injury, I understand that all reasonable efforts will be made to contact me but failure to contact will not prevent emergency treatment if necessary to preserve life or health.

Signature: _____ **Date:** _____

Measles, Mumps, Rubella (Required) 2 doses of vaccine **OR** a blood test showing immunity	Dose 1 ____/____/____ MM / DD / YR	Dose 2 ____/____/____ MM / DD / YR

***Hepatitis B (Required OR Waiver)** 3 doses of vaccine **OR** a blood test showing immunity	Dose 1 ____/____/____ MM / DD / YR	Dose 2 ____/____/____ MM / DD / YR	Dose 3 ____/____/____ MM / DD / YR

***Meningococcal Meningitis Serogroups (Required OR Waiver)** 1 dose since age 16. (such as Menactra, Mencevax, Menomune, MCV4, Menveo, and ACYW-135)	Dose 1 ____/____/____ MM / DD / YR	Dose 2____/____/____ MM / DD / YR	

***Waiver information:** I have received the required information regarding the risk of acquiring Meningococcal Meningitis and Hepatitis B and the benefits of receiving immunizations to reduce those risk. I also understand that I am required to receive these immunizations or to actively decline the immunizations by filling in the date in the spaces provided (on right) 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**	Hep B Waiver ____/____/____ MM / DD / YR	Meningitis Waiver ____/____/____ MM / DD / YR

Meningitis B (optional) Please circle type of vaccine (Bexsero or Trumenba)

Meningitis B Dose 1 ____/____/____ MM / DD / YR	Meningitis B Dose 2 ____/____/____ MM / DD / YR	Meningitis B Dose 3 ____/____/____ MM / DD / YR

Tetanus-Diphtheria and Pertussis (Tdap) **(Required for Athletes)** Incoming students should have one Tdap booster at 11 years of age or older. Receiving the Td (Tetanus - diphtheria) vaccination does not satisfy this requirement.	Tdap ____/____/____ MM / DD / YR	Td ____/____/____ MM / DD / YR

Varicella (Chicken Pox) 2 doses of vaccine **OR** provider's documentation of Illness	Dose 1 ____/____/____ MM / DD / YR	Dose 2 ____/____/____ MM / DD / YR

Part B Authorization and Additional Comments: The immunizations dates and any statements of contraindications 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

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