



# Saint Martin's UNIVERSITY

## STUDENT INTAKE AND EMERGENCY INFORMATION FORM

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MIDDLE INITIAL \_\_\_\_\_

STUDENT ID # \_\_\_\_\_

HOME STREET ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ MOBILE PHONE \_\_\_\_\_

IN CASE OF EMERGENCY CALL \_\_\_\_\_

EMERGENCY CONTACT DAY PHONE \_\_\_\_\_ EVENING PHONE \_\_\_\_\_ MOBILE PHONE \_\_\_\_\_

EMERGENCY CONTACT STREET ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

### The following information will be used for emergency use only:

HEALTH INSURANCE COMPANY \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_

CURRENT PHYSICIAN NAME \_\_\_\_\_ PHYSICIAN NUMBER \_\_\_\_\_

STUDENT'S BIRTH DATE \_\_\_\_\_ STUDENT'S BIRTH CITY \_\_\_\_\_

MOTHER'S/ GUARDIAN'S NAME \_\_\_\_\_ FATHER'S/ GUARDIAN'S NAME \_\_\_\_\_

### Please complete as applicable. Use the back of the form if necessary.

ALLERGIES \_\_\_\_\_

ALLERGIES TO MEDICATION \_\_\_\_\_

PREVIOUS SURGERIES/ MEDICAL CONCERNS \_\_\_\_\_

Are you currently taking any medications? \_\_\_\_\_ YES \_\_\_\_\_ NO If yes, please list.

The completion of this form DOES NOT waive the mandatory health insurance requirement with the University. Students who have satisfactory personal health insurance coverage must submit an online waiver by the designated day of each semester.



# Saint Martin's UNIVERSITY

## STUDENT IMMUNIZATION FORM

Name: _____	SMU ID#: _____
Date of Birth: _____	Phone: _____

Saint Martin's University adopted an immunization requirement from recommendations from the US Center for Disease Control ([www.cdc.gov](http://www.cdc.gov)), the American College Health Association ([www.acha.org](http://www.acha.org)) and state and local Public Health Departments. University students are at greater risk for contracting a variety of diseases. If you do not have recommended protection, in the event of an outbreak you would be asked to leave campus. **The requirement applies to all new undergraduate and graduate students born on or after January 1, 1957. To meet the requirement you need to complete and sign this form and document one of the options below. Vaccinations can be obtained at the SMU Health Center upon request ([healthcenter@stmartin.edu](mailto:healthcenter@stmartin.edu)).**

**Proof of the required immunizations or waiver MUST be on record at the Student Health Center in order to register for classes.**

**PLEASE COMPLETE ONE OF THE THREE OPTIONS:**

**OPTION 1: Document proof or Signature from a doctor/clinic that you have had one MMR vaccine and either a second MMR or a Measles only vaccine since 1969.**

Date of the <i>First</i> Immunization: _____	Date of the <i>Second</i> Immunization: _____
Signature(Health Care Provider) _____	Signature(Health Care Provider) _____
Address: _____	Address: _____
Phone: _____	Phone: _____

**OPTION 2: Documented proof or Signature from a doctor/clinic that you had the measles disease (rubeola).**

Date of Measles case/diagnosis: _____	Health Care Provider Signature _____
Address: _____	Phone: _____

**OPTION 3: Documented proof or Signature from a doctor/clinic that you have had a positive measles (rubeola) antibody test.**

Date of blood test: _____	Health Care Provider Signature _____
Address: _____	Phone: _____

**PLEASE ATTACH A COPY OF YOUR IMMUNIZATION RECORDS. DO NOT SEND ORIGINALS.**  
*I certify that the above statement(s) are accurate and true to the best of my knowledge.*

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If you wish to claim an exemption, please email [healthcenter@stmartin.edu](mailto:healthcenter@stmartin.edu) to receive a copy of the exemption form.



# Saint Martin's UNIVERSITY

## RECOMMENDED (BUT NOT REQUIRED) IMMUNIZATIONS

Name: \_\_\_\_\_ SMU ID#: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

**Tetanus/Diphtheria**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Month Day Year

OR

**Tdap (Tetanus/diphtheria/pertussis)**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Month Day Year

**Hepatitis A #1**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Month Day Year

**Hepatitis A #2**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Month Day Year

**Hepatitis B #1**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Month Day Year

**Hepatitis B #2**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Month Day Year

**Hepatitis B #3**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Month Day Year

**Meningococcal (Meningitis)** \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Month Day Year

**HPV(Gardasil) #1**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Month Day Year

**HPV(Gardasil) #2**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Month Day Year

**HPV(Gardasil) #3**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Month Day Year

**Polio:** Completed Primary Series of Polio Immunization? \_\_\_\_ Yes \_\_\_\_ No

Date of 5<sup>th</sup> Dose: \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Month Day Year

**Varicella (Chicken Pox):** Had Disease? \_\_\_\_ Yes \_\_\_\_ No

<b>Vaccination #1</b> _____/_____/_____ Month Day Year	<b>Vaccination #2</b> _____/_____/_____ Month Day Year
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**Other Vaccinations (Typhoid, Yellow Fever, etc.)**

TYPE: \_\_\_\_\_  
Month Day Year

TYPE: \_\_\_\_\_  
Month Day Year



# Saint Martin's UNIVERSITY

**Saint Martin's University Health Center Consent and Decree  
THIS DOCUMENT HAS LEGAL SIGNIFICANCE. PLEASE READ CAREFULLY.**

**Saint Martin's University will keep your medical records confidential to the extent allowed by law and the records will only be used for the provision of health care services. You, as the students, must inform Residence Hall staff or other University personnel (i.e. physical education instructors or athletic coaches) of any medical condition that you have that could be of concern while you are attending SMU. Furthermore, you are responsible for wearing a MedicAlert bracelet, necklace or similar device to warn health care providers of your diabetes, hemophilia, heart disease, seizure disorder, drug allergies, or other significant medical conditions.**

**In the event SMU is required to rely on this consent to authorize necessary medical care and treatment for the student, the undersigned, individually and jointly, agree to indemnify and hold SMU harmless for the costs incurred for said emergency care and treatment, including reasonable attorney fees and costs incurred in defending and/or instituting a suit to recover said medical expenses.**

*As an SMU student, I consent to any medical or surgical treatment in the event of a medical emergency as confirmed by an attending physician, or other medical professional at the SMU Health Center. If I am under 18 years of age, SMU will attempt to contact the undersigned parent or guardian for approval before relying on this consent. In addition, I must personally consent to said medical procedures if I am physically and emotionally capable of consenting at the time such treatment is required.*

*I declare, under penalty of perjury under laws of the State of Washington, that the forgoing is true and correct.*

\_\_\_\_\_  
STUDENT SIGNATURE (Please PRINT and SIGN your name.)

\_\_\_\_\_  
DATE AND PLACE

\_\_\_\_\_  
PARENT OR GUARDIAN SIGNATURE (Required if student is under 18 years of age.)

\_\_\_\_\_  
DATE AND PLACE