Saint Martin's UNIVERSITY

NURSING STUDENT IMMUNIZATION HISTORY & EMERGENCY INFORMATION

Name ______________________________ ______________________________
First Name Last Name Primary Phone Number

Address ____
Street City State Zip

Date of Birth ____/____/________ Gender (check one): Male Female Trans Starting Semester and Year __________________

SMU ID # __________________________________ SMU email address__________________________________

Status: Freshman _____ Transfer _____ Graduate _____ International ____ Country ______________________

The following information will be used for emergency use only:

Emergency contact name and phone number____

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

Medical History ______________________________ ______________________________
Allergies Medications

____
Medical Concerns/Previous Surgeries

A COPY OF YOUR IMMUNIZATION RECORDS IS REQUIRED. DO NOT SEND ORIGINALS.

University students are at greater risk for contracting a variety of diseases. Saint Martin's University follows immunization requirement recommendations from the Center for Disease Control (www.cdc.gov), the American College Health Association (www.acha.org) and state and local Public Health Departments.

To meet the requirements, please complete and sign forms AND attach your immunization records. Then upload ALL to your enrolling portal. Titers and MMR/MCV vaccines are available at the SMU Student Health Center upon request (healthcenter@stmartin.edu). Insurance card needed for titers. Fees to student account apply for vaccines.

REQUIRED IMMUNIZATION FOR ALL NURSING STUDENTS

COVID vaccine Copy of card or record must be attached

1. Dose 1………………………………………………Brand: ___________________________#1 ____/____/_____
   M D Y
2. Dose 2 ………………………………………………Brand: ___________________________#2 ____/____/_____
3. Bivalent booster dose within the last 12 months......Brand: ___________________________#3____/____/______

REQUIRED IMMUNIZATION FOR ALL STUDENTS LIVING IN THE RESIDENCE HALLS

MENINGOCOCCAL QUADRIVALENT (MCV or MCV4) Record must be attached

(A, C, Y, W-135) One or 2 doses within the last 5 years **for all college students living in the residence halls** – revaccinate every 5 years

1. Quadrivalent polysaccharide (Menveo or Menactra)

   Date ____/____/______

Health Science Initial Immunization Record (Copy of records must be attached)

Student Name:____

Influenza Vaccine: 1 dose Quadrivalent (required annually – document most recent).				
Mo./day/year				
Tetanus/Diphtheria/Pertussis: 1 dose of adult TDaP from within the last 10 years.				
TDaP booster must have one documented	Mo./day/year			
Measles/Mumps/Rubella: 2 doses of MMR at least 28 days apart after 12 months of age OR 2 doses of Measles and 2 doses of Mumps at least 28 days apart after 12 months of age and 1 dose of Rubella after 12 months of age OR laboratory proof of immunity (blood titer) to measles/mumps/rubella. If titers are negative or equivocal, administer MMR series with doses at least 28 days apart. No titer is required after series completion.				
MMR 2 required on or after 1st birthday	(#1) Mo./day/year	(#2) Mo./day/year		
OR				
Measles 2 required on or after first birthday	(#1) Mo./day/year	(#2) Mo./day/year		
Mumps 2 required on or after first birthday	(#1) Mo./day/year	(#2) Mo./day/year		
Rubella 1 required on or after first birthday	Mo./day/year			
OR				
MMR Titer must attach laboratory results	Date of Titer	Result		
Varicella: 2 doses of Varicella at least 4 weeks apart OR laboratory proof of immunity to varicella. If titer is negative or equivocal, administer Varicella series with doses at least 4 weeks apart. No titer is required after series.				
Varicella 2 doses	(#1) Mo./day/year	(#2) Mo./day/year		
OR				
Varicella Titer must attach laboratory results	Date of Titer	Result		
Hepatitis B: 3 doses of hepatitis B vaccines and a positive (≥10 mIU/mL) serological <u>quantitative</u> hepatitis B surface antibody titer (HBsAb) 1-2 months after the date of the last vaccine is considered proof of lifelong immunity. If series was completed in the remote past, and if the titer checked upon matriculation is negative, student will get 1 hepatitis B vaccine dose (#4) and re-titer at least 1-2 months after vaccine. If the second titer is negative, student will get 2 additional hepatitis B vaccines (#5 and #6) per the standard schedule. A final titer should be done 1-2 months after the 6th vaccine and if this is negative, the student should be considered a non-responder and evaluated and counseled appropriately. Those students recently vaccinated with a negative titer after the 3rd dose can receive a second series with a re-titer 1-2 months after the 6th dose. Non-responders should be counseled and evaluated appropriately.				
Hepatitis B Series 2 or 3 doses required depending on vaccine formulation	(#1) mo./day/year Adult formulation ____ Child formulation ____ HepB-CpG (Heplisav-B) ____	(#2) mo./day/year Adult formulation ____ Child formulation ____ HepB-CpG (Heplisav-B) ___	(#3) mo./day/year Adult formulation ____ Child formulation ____ HepB-CpG (Heplisav-B) ___	
Hepatitis B Quantitative Titer must attach laboratory results	Date of Titer	Result		
Hepatitis B Series Repeat	(#1) mo./day/year	(#2) mo./day/year	(#3) mo./day/year	
Hepatitis B <u>Quantitative</u> Titer Repeat must attach laboratory results	Date of Titer	Result		
Tuberculin Skin Test (TST) or IGRA: 2 TSTs placed within the last 12 months within the United States. The 2nd TST must be placed at least 1 week AFTER the 1st TST read date.				
2 Step TST placed within the past 12 months	1st TST Place date	1st TST Read Date	2nd TST Place Date	2nd TST Read date
OR				
IGRA TB Screening must attach laboratory results __ T-Spot __ Quantiferon Gold	Date of IGRA	Result		

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 student, 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.

Forms MUST be completed fully and accurately with necessary documentation attached and be on record at the Student Health Center or a HOLD will be placed on the student's account after the last day of the add/drop period.

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 Student 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 foregoing is true and correct.

____________________	____________________
SIGNATURE **(Please PRINT and SIGN your name)**	**DATE**
____________________	____________________
PARENT OR GUARDIAN SIGNATURE **(Required if student is under 18 years of age)**	**DATE**

Saint Martin's University: Department of Nursing

Authorization to Release Protected Health Information

Legal Name____ **DOB** _____/_____/_____
First *Last* *Month* *Day* *Year*

Mailing Address ____
Street *Apt#*
_____________________________________ **Phone number:**
____
City, State, Zip

Information To Be Released TO:	**Information To Be Released FROM:**
Department of Nursing Saint Martin's University 5000 Abbey Way SE, Old Main Lacey, WA 98503 Nursing@stmartin.edu (360) 688-2637	Health Center Saint Martin's University 5000 Abbey Way SE, Burton Hall Lacey, WA 98503 Healthcenter@stmartin.edu (360) 412-6160

Type of information to be released - Initials REQUIRED:
Immunization records and health documentation required to participate in clinical studies.

INITIALS: _________

Patient/Client Authorization - Initials REQUIRED:
I understand that my records may contain information regarding physical illness, a history of immunization, and some medical procedures. I give my special authorization for this information to be released.

INITIALS: _________

This release is effective as long as I am enrolled at SMU - Initials REQUIRED.

INITIALS: _________

MY RIGHTS
I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form in order to take part in a research study OR to receive health care when the purpose is to create health information for a third party. I may revoke this authorization in writing. If I did, it would not affect any actions already taken by the SMU Health Center and Department of Nursing based upon this authorization. The way to revoke this authorization is to write a letter to: SMU Health Center; Attn: Director, 5000 Abbey Way SE; Lacey WA, 98503. Once the SMU Health Center discloses health information, the person or organization that receives it, may elect to re-disclose it. Privacy laws may no longer protect it.

Signature of Patient/Client: ______________________________________ **Date:** _____/_____/_____

Signature of Witness: ____**Date:** _____/_____/_____