Saint Martin's
UNIVERSITY

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 ________________________
M D Y

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 RECORD(S)IS ALSO REQUIRED

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. Exemption inquiries please email healthcenter@stmartin.edu. The requirements apply to all new undergraduate and graduate students born on or after January 1, 1957. **To meet the requirements, please complete and sign this form and attach your immunization records.**
The MMR and MCV vaccines may be obtained at the SMU Student Health Center upon request for a fee.

REQUIRED IMMUNIZATION FOR ALL STUDENTS (nursing students, please use nursing forms)

OPTION 1: MMR (MEASLES, MUMPS, RUBELLA) Copy of record must be attached
(Two doses required at least 28 days apart for students born after 1956 and all health care professional students.)

Dose 1 given at age 12 months or later ……………………………………………………….#1 ____/____/___

Dose 2 given at least 28 days after first dose ………………………………………………...#2 ____/____/___

OPTION 2: Documented proof that you have had a positive measles (rubeola) antibody test. Attach copy of results.

Date of Test ____/__ __/_____

REQUIRED IMMUNIZATION FOR ALL STUDENTS LIVING ON CAMPUS

MENINGOCOCCAL QUADRIVALENT (MCV or MCV4) Copy of record must be attached

(A, C, Y, W-135) One dose 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 ____/____/______

RECOMMENDED IMMUNIZATIONS (not currently required)

Current COVID bivalent booster, Current FLU vaccine, POLIO series, VARICELLA series
TETANUS, DIPHTHERIA, PERTUSSIS(Tdap) within the last 10 years
HUMAN PAPILLOMAVIRUS VACCINE series (GARDASIL 9),MENINGOCOCCAL B (Men B)
HEPATITIS A series, HEPATITIS B series, PNEUMOCOCCAL POLYSACCHARIDE VACCINE

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 SIGN and PRINT your name)**	**Printed name**	**DATE**
PARENT OR GUARDIAN SIGNATURE **(Required only if student is under 18 years of age at time of signing)**	**Printed name**	**DATE**