



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 _____

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. 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 (healthcenter@stmartin.edu).

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.)

1. Dose 1 given at age 12 months or later #1 / /
M D Y
2. 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 / /

COVID vaccine Copy of card or record must be attached

1. Dose 1.....Brand: _____ #1 / /
M D Y
2. Dose 2Brand: _____ #2 / /
3. Booster Dose(recommended):Brand: _____ #3 / /

REQUIRED IMMUNIZATION FOR ALL STUDENTS LIVING IN THE RESIDENCE HALLS

MENINGOCOCCAL QUADRIVALENT (MCV or MCV4)

(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 conjugate (preferred; administer simultaneously with Tdap if possible).
 - a. Dose #1 / / b. Dose #2 / /
M D Y M D Y
 - b. Dose #2 / /
2. Quadrivalent polysaccharide (acceptable alternative if conjugate not available).
 Date / /

RECOMMENDED IMMUNIZATIONS (not currently required)

**Current FLU vaccine, POLIO series, VARICELLA series
TETANUS, DIPHTHERIA, PERTUSSIS(Tdap) within the last 10 years
HUMAN PAPILLOMAVIRUS VACCINE series (HPV2 or HPV4), 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 **Printed name** **DATE**
(Please SIGN and PRINT your name)

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