Saint Martin's UNIVERSITY

STUDENT IMMUNIZATION HISTORY & EMERGENCY INFORMATION

Name _____ _____
First Name Last Name

Address _____
Street City State Zip

Date of Birth ____/____/_____ Gender (circle one): Male Female Trans Starting Semester and Year _____
M D Y

Status: Freshman _____ Transfer _____ ESL _____ Graduate _____

International Students: Home Country _____

The following information will be used for emergency use only:

Emergency contact name and phone number_____

Health insurance _____ _____ _____
Company Subscriber Name and Date of Birth Group Number

Health insurance is required by the University. 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 to Student Financial Services - Student Accounts, OM 250, 360-438-4389.

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

Medical History_____ _____
Allergies Medications

_____
Medical Concerns/Previous Surgeries

TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER.

All information must be in English

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

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. 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. The MMR vaccine may be obtained at the SMU Student Health Center upon request (healthcenter@stmartin.edu).

REQUIRED IMMUNIZATION FOR ALL STUDENTS

COMPLETE ONE OF THE TWO OPTIONS:

OPTION 1: MMR (MEASLES, MUMPS, RUBELLA)

(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 ____/____/_____
M D Y

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

Date of Test ____/_____

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First Name Last Name

REQUIRED IMMUNIZATIONS FOR ALL STUDENTS LIVING IN THE RESIDENCE HALLS

MENINGOCOCCAL QUADRIVALENT

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

1. Quadrivalent conjugate (preferred; administer simultaneously with Tdap if possible).

   a. Dose #1 ____/____/_____ (M D Y) b. Dose #2 ____/____/_____ (M D Y)

2. Quadrivalent polysaccharide (acceptable alternative if conjugate not available).

   Date ____/____/_____ (M D Y)

RECOMMENDED IMMUNIZATIONS

POLIO

(Primary series, doses at least 28 days apart. Three primary series are acceptable. See ACIP website for details.)

1. OPV alone (oral Sabin three doses): #1 ____/____/_____ (M D Y) #2 ____/____/_____ (M D Y) #3 ____/____/_____ (M D Y)
2. IPV/OPV sequential: IPV #1 ____/____/_____ (M D Y) IPV #2 ____/____/_____ (M D Y) OPV #3 ____/____/_____ (M D Y) OPV #4 ____/____/_____ (M D Y)
3. IPV alone (injected Salk four doses): #1 ____/____/_____ (M D Y) #2 ____/____/_____ (M D Y) #3 ____/____/_____ (M D Y) #4 ____/____/_____ (M D Y)

VARICELLA

(Birth in the U.S. before 1980, a history of chicken pox, a positive varicella antibody, or two doses of vaccine meets the requirement.)

1. History of Disease Yes ___ No ___ or Birth in U.S. before 1980 Yes ___ No ___
2. Varicella antibody ____/____/_____ (M D Y) Result: Reactive _____ Non-reactive _____
3. Immunization
   a. Dose #1 . ..... #1 ____/____/_____ (M D Y)
   b. Dose #2 given at least 12 weeks after first dose ages 1-12 years. ..... #2 ____/____/_____ (M D Y)
   and at least 4 weeks after first dose if age 13 years or older.

TETANUS, DIPHTHERIA, PERTUSSIS

1. Date of most recent booster dose: ____/____/_____ Type of booster: Td _____ Tdap _____

Tdap booster recommended for ages 11-64 unless contraindicated.

HUMAN PAPILLOMAVIRUS VACCINE (HPV2 or HPV4)

(Three doses of vaccine for females and males 11-26 years of age at 0, 1-2, and 6 month intervals.)

Immunization (indicate which preparation) Quadrivalent (HPV4) _____ or Bivalent (HPV2) _____

a. Dose #1 ____/____/_____ (M D Y) b. Dose #2 ____/____/_____ (M D Y) c. Dose #3 ____/____/_____ (M D Y)

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HEPATITIS A

1. Immunization (hepatitis A)

   a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____
   M D Y M D Y

2. Immunization (Combined hepatitis A and B vaccine)

   a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____ c. Dose #3 ____/____/_____
   M D Y M D Y M D Y

HEPATITIS B

(All college and health care professional students. Three doses of vaccine or two doses of adult vaccine in adolescents 11-15 years of age, or a positive hepatitis B surface antibody meets the requirement.)

1. Immunization (hepatitis B)

   a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____ c. Dose #3 ____/____/_____
   M D Y M D Y M D Y

   Adult formulation ____ Child formulation ____ Adult formulation ____ Child formulation ____ Adult formulation ____ Child formulation ____

2. Immunization (Combined hepatitis A and B vaccine)

   a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____ c. Dose #3 ____/____/_____
   M D Y M D Y M D Y

3. Hepatitis B surface antibody Date ____/____/_____ Result: Reactive _____ Non-reactive _____
   M D Y

PNEUMOCOCCAL POLYSACCHARIDE VACCINE

(One dose for members of high-risk groups.)

Date ____/____/_____
M D Y

HEALTH CARE PROVIDER ONLY

Name _____ Signature _____

Address _____ Phone (_____) _____

If you wish to claim an exemption, please email healthcenter@stmartin.edu to receive a copy of the exemption form.

Saint Martin's UNIVERSITY

Name _____ _____
First Name Last Name

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.

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 **DATE**
(Please PRINT and SIGN your name)

_____ _____
PARENT OR GUARDIAN SIGNATURE **DATE**
(Required if student is under 18 years of age)