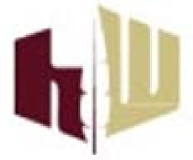
THE FLORIDA STATE UNIVERSITY

UNIVERSITY HEALTH SERVICES

HEALTH & WELLNESS CENTER



Part A—Print or type. Illegible forms will not be processed.

STUDENT NAME: Last ______________________________First___________________________MI_________

DATE OF BIRTH: ____/___/______ FSU EMPLID ________________ Gender: ◯Male ◯Female◯Other Race: _____________

Home Phone: _____________________ Cell Phone: ________________________ E-mail: ______________________________

Part B	**REQUIRED IMMUNIZATIONS**		
Combined MMR dates No single shots	Dose 1 / / On or after first birthday	Dose 2 / / At least 28 days later	Titers: document attached
Meningococcal Meningitis dates	Dose 1 / /	Dose 2, if applicable	
Meningococcal Meningitis	Waiver ☐ Student Initials ___________	Date / / of waiver (REQUIRED)	
Hepatitis B dates	Dose 1 / /	Dose 2 / /	Dose 3 / /
Hepatitis B	Waiver ☐ Student Initials___________	Date / / of waiver (REQUIRED)	Titer: document attached

Waiver Information: I have received the required information regarding the risks of acquiring meningococcal meningitis and Hepatitis B and the benefits of receiving immunizations to reduce those risks. I also understand that I am required to receive these immunizations or to actively decline the immunizations by placing my initials in the space(s) **provided above**. I understand that I may decline either or both immunizations and that declining these vaccines now does not mean I may not receive them in the future. ______________________________________

patient signature

Part C: AUTHORIZATION and additional comments: The immunization dates and any statements of contraindication to immunizations entered on this document are, as of the date signed, verified by my signature below. Additional physician comments: ____

____

Clinician or Records Custodian Name

________________________________ ________

Clinician or Records Custodian Signature Date Office Stamp

HEALTH INSURANCE DECLARATION

I acknowledge that I am a transient student participating in an International Study Abroad Program at Florida State University.

I understand that I am required to maintain health insurance coverage that is compliant with PPACA (the Affordable Care Act) while I am overseas.

My health insurance carrier is ____

My coverage began on this date: ____________________________ **My policy number is:** ____________________ **Group number is:** __________

Signature: ____ Date:___________________

IP Transient Student Immunization-Insurance Record fax to 850-644-8958 or mail to 960 Learning Way, Tallahassee, FL 32306-4178