# *Florida State University*
# Immunization Form Instructions

Use the instructions on this page as a guide to complete the Immunization Form.

**Section 1:**
List any relevant personal and family medical history, and any known allergies, including medications.

**Section 2:**
If you are under 18, this Section is required to be signed by your parent or guardian to allow us to administer medical treatment if necessary.

**Section 3:**
This section should be completed by your healthcare provider's office. Measles, Mumps, Rubella (MMR) is a required immunization for students born on or after January 1, 1957.

You must provide proof of two combined MMR (measles {rubeola}, mumps, rubella) immunizations.
The first MMR must have been given on or after January 1, 1968 and on or after the first birthday.
The second MMR immunization must have been given 28 days or more after the first MMR.

**Section 4:**
This section should be completed by your healthcare provider's office. Hepatitis B is a recommended but not required immunization. You may choose to opt out of this series by completing Section 6.

**Section 5:**
This section should be completed by your healthcare provider's office. Meningitis is a recommended but not required immunization. You may choose to opt out of this series by completing Section 6.

**Section 6:**
This is where you may elect to opt out of the Hepatitis B and/or the Meningococcal Meningitis immunization series as referenced in the instructions for Sections 4 and 5 above. Section 6 requires you to mark the box next to the immunization(s) you wish to opt out of and to sign and date. Note that failure to sign and date your decision to opt out of the Hepatitis B and/or Meningitis vaccines will prevent us from processing this form and a hold will remain on your student account.

**Section 7:**
This section should be completed by your healthcare provider's office if you have received the Meningitis B immunization series. (This is not a required immunization.)

**Section 8:**
This section should be completed by your healthcare provider's office if you have received the COVID-19 Vaccination. COVID-19 is a recommended but not required immunization.

**Section 9:**
This section should be completed by your healthcare provider's office if you have received the Tetanus-Diptheria-Pertussis (TDaP) immunization. (This is not a required immunization unless you are an NCAA Athlete.)

**Section 10:**
This section is the Authorization that the information on the form is accurate. This Section must be completed by your healthcare provider's office, and must be signed, dated and must have an official office stamp.

**Once completed**: You may submit this form to the Health Compliance Office in one of the following ways:
**Email:** healthcompliance@fsu.edu Please be aware that email sent over the Internet is not considered secure. FSU shall not be liable for any breach of confidentiality resulting from this form of communication.
**Fax:** 850-644-8958
**Mail:** 960 Learning Way, Tallahassee, FL 32306-4178
**FSU Dropbox:** https://dropbox.fsu.edu
**In Person:** You may also drop off your forms In Person to the Health Compliance office at UHS during regular business hours http://uhs.fsu.edu/about/contact-us at 960 Learning Way.

Unless otherwise indicated, University Health Services recommends students receive the optional immunizations listed above. To schedule an appointment, please call 850-644-4567.

*FLORIDA STATE UNIVERSITY*

# *Immunization Form*

**Part A– Print or type. Illegible form will not be processed**

LAST NAME: _____ FIRST NAME: _____ DOB: _____

EMPLID_____ EMAIL_____ PRIMARY PHONE#_____

1. Please list any relevant personal and family medical history: _____

Do you have any allergies (including Medications): No ☐ Yes ☐ Please list if yes:_____

2. **REQUIRED AUTHORIZATIONS FOR CARE FOR STUDENTS UNDER THE AGE OF 18:** I authorize health center personnel to provide medical and surgical care including examinations, treatment, immunizations and the like for my son/daughter. In the event of serious disease or injury, I understand that all reasonable efforts will be made to contact me but failure to contact will not prevent emergency treatment if necessary to preserve life or health.

**Signature:** _____ **Date:** _____

| | | | |
|---|---|---|---|
| 3. | **Measles, Mumps, Rubella (Required)**<br>2 doses of vaccine **OR** a blood test showing immunity | Dose 1 ____/____/____<br>MM / DD / YR | Dose 2 ____/____/____<br>MM / DD / YR |
| 4. | ***Hepatitis B (Required or Complete Section 6)**<br>3 doses of vaccine **OR** a blood test showing immunity | Dose 1 ____/____/____<br>MM / DD / YR | Dose 2 ____/____/____<br>MM / DD / YR<br>Dose 3 ____/____/____<br>MM / DD / YR |
| 5. | ***Meningococcal Meningitis Serogroups (Required or Complete Section 6)**<br>1 dose since age 16. (such as Menactra, Mencevax, Menomune, MCV4, Menveo, and ACYW-135) | Dose 1 ____/____/____<br>MM / DD / YR | Dose 2____/____/____<br>MM / DD / YR |

6. ***Waiver information:** I have received the required information regarding the risk 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 checking the boxes and signing below. 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:** _____ **Date:** _____

☐ **Meningitis Waiver** ☐ **Hepatitis B Waiver**

**Meningitis B (Optional)** Please circle type of vaccine (Bexsero or Trumenba)

| | | | |
|---|---|---|---|
| 7. | Meningitis B Dose 1 ____/____/____<br>MM / DD / YR | Meningitis B Dose 2 ____/____/____<br>MM / DD / YR | Meningitis B Dose 3 ____/____/____<br>MM / DD / YR |
| 8. | **COVID-19 Vaccine (Optional)** Please circle type of vaccine (Pfizer/Moderna/Janssen) | Dose 1 ___/____/_____<br>MM / DD / YR | Dose 2 ____/____/____<br>MM / DD / YR |
| 9. | **Tetanus-Diphtheria and Pertussis (Tdap) (Optional) (Required for NCAA Athletes)**<br>**Incoming students should have one Tdap booster at 11 years of age or older.** | | Tdap ____/____/____<br>MM / DD / YR |

**This section to be completed by your healthcare provider**

10. **Authorization and additional comments:**
The immunizations dates and any statement of contraindications to immunizations entered on this document are, as of the date signed, verified by my signature below. Additional comments:_____

_____
Clinician **OR** Records Custodian Name

_____ _____
Clinician **OR** Records Custodian Signature **DATE** OFFICE STAMP

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