EMBRY RIDDLE AERONAUTICAL UNIVERSITY
PRESCOTT CAMPUS

Fax 928-777-3850 or email
PRWellnessCenter@erau.edu

COMPLETED FORM MUST BE RETURNED TO WELLNESS CENTER PRIOR TO ENROLLMENT

For Office Use Only:
OK to FILE:_____

MISSING	**X**
NEEDS ALL	
MMR1	
MMR2	
HB1	
HB2	
HB3	
MEN	
TB	
CHEST X-RAY	
WAIVERS	**X**
MMR	
HB	
MNG	

STUDENT ID#_____

E-mail:_____

Cell#:_____

Will reside in University Housing? _____ Yes_____ No
Do you intend to be immunized at ERAU____Yes_____ No
Will you participate in the Student Insurance Plan _____Yes____No
If not, a copy of your current insurance plan must be attached to this form.

PERSONAL DATA-- ***Please print legibly***

Expected Date of Entry ___/___/_____ Degree Program_____

Name_____
Last First Middle

Date of Birth ___/___/_____ Sex____ Height_____ Weight_____ Marital Status_____

Permanent Address_____
No. & street City State/Zip Code Country Phone

Emergency Contact_____Phone (1)_____(2)_____

PERSONAL MEDICAL HISTORY

Do you have any allergies? If so, please indicate (include medications, insect stings, environmental factors,food):

_____
_____

Are you currently under the care of any clinical practitioner for medical, psychological or dependency issues? Please list and attach summary.

_____

List medications taken recently or currently (include birth control, vitamins and herbal preparations):

_____

EMBRY-RIDDLE AERONAUTICAL UNIVERSITY HEALTH SERVICES

NAME_____ Student ID#_____ BIRTHDAY_____/_____/_____

REQUIRED IMMUNIZATION DATA
The immunization policy is designed to protect the health of all students. **Students who fail to comply will have a HOLD placed on class registration and/or will be denied class attendance pending satisfactory completion of required data.**
A licensed health care provider must certify immunization data; home records or self-reports are unacceptable. Copies of school or military immunization records will be accepted with appropriate dates and signatures indicated.

A. MMR (MEASLES/MUMPS/RUBELLA): All students born after Dec. 31, 1956 must provide proof of two doses administered on or after the first birthday. The second dose of MMR must be administered 30 days or more after the first dose. Alternately, students may provide copies of laboratory reports indicating positive antibody titers for these diseases. Students born prior to Dec. 31, 1956 are considered to have natural immunity.

1st MMR ____/____/____ 2nd MMR ____/____/____

HEPATITIS B AND MENINGOCOCCAL MENINGITIS: Please log onto
http://prescott.erau.edu/campus-services/wellness/health-and-wellness-center.html

for information regarding these diseases and their prevention through vaccination**. All students who reside in University Housing must either document the immunizations for Hepatitis B and meningococcal meningitis OR complete the waiver in section B below.** We urge you to discuss these concerns with your personal physician and consider vaccination. **There will be opportunities for vaccination at campus-sponsored clinics during Orientation and campus-specific dates to be announced.**

Hepatitis B dose 1: ____/____/____ Meningococcal Meningitis ____/____/____
dose 2: ____/____/____
dose 3: ____/____/____
TB tests are required for any student from a high endemic country. Testing will be done on affected students upon arrival to campus.

_____ ____/____/____ _____
Physician or authorized signature date License # & Office Stamp with Address

B. I have read the detailed information provided regarding the risks of contracting meningococcal meningitis and Hepatitis B disease and the potential benefits of being vaccinated to reduce those risks.

☐ I decline to receive Hepatitis B vaccines.
☐ I decline to be vaccinated for meningococcal meningitis.

_____ Date ____/____/____
Student Signature
_____ Date ____/____/____
AND by parent or legal guardian if under 18 and single

AUTHORIZATION FOR TREATMENT
I hereby grant permission to the Wellness Center or Counseling Center staff of Embry-Riddle Aeronautical University or the University Physician(s) to render any health care or emergency treatment to myself/son/daughter/ward. I also grant permission for the above referenced ERAU staff to arrange for health care, emergency treatment or hospitalization at an accredited hospital or other medical, psychological or dental care facility when considered necessary by the Wellness Center or Counseling Center staff or University Physician(s).

Signed _____ Date ____/____/____
Student's Signature

AND by parent or legal guardian if under 18 and single

Signed _____ Date ____/____/____