

EMBRY-RIDDLE AERONAUTICAL UNIVERSITY
WELLNESS CENTER
PRESCOTT CAMPUS
Fax 928-777-3850 or email
prwellnesscenter@erau.edu

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 card MUST be attached to this form.

For Office Use Only:

OK to FILE:

MISSING	X
NEEDS ALL	
MMR1	
MMR2	
HB1	
HB2	
HB3	
MEN	
WAIVERS	X
MMR	
HB	
MNG	

COMPLETED FORM MUST BE RETURNED TO WELLNESS CENTER PRIOR TO ENROLLMENT
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 WELLNESS CENTER

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 OR a copy of school or military immunization records will be accepted with appropriate dates and signatures indicated. All records MUST be in English.

MMR (MEASLES/MUMPS/RUBELLA): ARS-15-872. Due to the recent outbreak of measles across the United States the University has revised its policy regarding participation on our campuses by individuals who have not been immunized against contagious diseases. **Students without the required immunizations will not be permitted on campus.**

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/wellness> for information regarding these diseases and their prevention through vaccination. Vaccinations are available at the Wellness Center.

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.

Hepatitis B dose 1: ____/____/____
dose 2: ____/____/____
dose 3: ____/____/____

Meningococcal Meningitis ____/____/____

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.

Student Signature Date ____/____/____

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 ____/____/____