Saint Martin's UNIVERSITY

STUDENT IMMUNIZATION FORM

Name:_____ **SMU ID#:**_____

Date of Birth:_____ **Phone:**_____

Saint Martin's University adopted an immunization requirement from recommendations from the US 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. Vaccinations can be obtained at the SMU Health Center upon request (healthcenter@stmartin.edu).**

COMPLETE ONE OF THE THREE OPTIONS:

OPTION 1: Documented proof or Signature from a doctor/clinic that you have had one MMR vaccine and either a second MMR or a Measles only vaccine since 1969.

Date of the ***First*** Immunization:_____	Date of the *Second* Immunization:_____
Signature(Health Care Provider) _____	Signature(Health Care Provider) _____
Address:_____	Address:_____
Phone:_____	Phone:_____

OPTION 2: Documented proof or Signature from a doctor/clinic that you had the measles disease (rubeola).

Date of Measles case/diagnosis:_____ Health Care Provider Signature_____
Address:_____ Phone:_____

OPTION 3: Documented proof or Signature from a doctor/clinic that you have had a positive measles (rubeola) antibody test and a copy of test results.

Date of blood test:_____ Health Care Provider Signature_____
Address:_____ Phone:_____

PLEASE ATTACH A COPY OF YOUR IMMUNIZATION RECORDS. DO NOT SEND ORIGINALS.

I certify that the above statement(s) are accurate and true to the best of my knowledge.

Student Signature: _____ **Date**: _____

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

Saint Martin's University
Student Health Center
360-412-6160 or Fax 360-486-8404
http://www.stmartin.edu/HealthCenter

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RECOMMENDED (BUT NOT REQUIRED) IMMUNIZATIONS

Name:_____ **SMU ID#:**_____

Date of Birth:_____ **Phone:**_____

Tetanus/Diphtheria
_____/_____/_____
Month Day Year

OR

Tdap (Tetanus/diphtheria/pertussis)
_____/_____/_____
Month Day Year

Hepatitis A #1
_____/_____/_____
Month Day Year

Hepatitis A #2
_____/_____/_____
Month Day Year

Hepatitis B #1
_____/_____/_____
Month Day Year

Hepatitis B #2
_____/_____/_____
Month Day Year

Hepatitis B #3
_____/_____/_____
Month Day Year

Meningococcal (Meningitis) _____/_____/_____
Month Day Year

HPV(Gardasil) #1
_____/_____/_____
Month Day Year

HPV(Gardasil) #2
_____/_____/_____
Month Day Year

HPV(Gardasil) #3
_____/_____/_____
Month Day Year

Polio: Completed Primary Series of Polio Immunization? _____ Yes _____ No
Date of 5th Dose: _____/_____/_____
Month Day Year

Varicella (Chicken Pox): Had Disease? _____ Yes _____ No

Vaccination #1	**Vaccination #2**
_____/_____/_____ Month Day Year	_____/_____/_____ Month Day Year

Other Vaccinations (Typhoid, Yellow Fever, etc.)
TYPE: _____ _____/_____/_____
Month Day Year
TYPE: _____ _____/_____/_____
Month Day Year

Saint Martin's UNIVERSITY

STUDENT INTAKE AND EMERGENCY INFORMATION FORM

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

STUDENT ID # _____

U.S. ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ MOBILE PHONE _____

EMERGENCY CONTACT (LOCAL) NAME _____ PHONE _____ RELATIONSHIP _____

ADDRESS _____ CITY _____ STATE _____ COUNTRY _____ ZIP _____

EMERGENCY CONTACT (HOME COUNTRY) NAME: _____ PHONE: _____ RELATIONSHIP: _____

ADDRESS _____ CITY _____ STATE _____ COUNTRY _____ ZIP _____

The following information will be used for emergency use only:

HEALTH INSURANCE COMPANY _____ GROUP NUMBER _____

CURRENT PHYSICIAN NAME _____ PHYSICIAN NUMBER _____

STUDENT'S BIRTH DATE _____ MM/DD/YYYY BIRTHPLACE CITY & COUNTRY _____

MOTHER'S/ GUARDIAN'S NAME _____ FATHER'S/ GUARDIAN'S NAME _____

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

ALLERGIES _____

ALLERGIES TO MEDICATION _____

PREVIOUS SURGERIES/ MEDICAL CONCERNS _____

Are you currently taking any medications? ☐ YES ☐ NO If yes, please list.

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.

Saint Martin's UNIVERSITY

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 and they will not be allowed to register for classes.

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 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 forgoing is true and correct.

_____ _____

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

_____ _____

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

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