Health and Wellness Center
Post Office Box 6665, MC 2214
Saint Leo, FL 33574
(352) 588-8347
(352) 588-8305 –Fax

Mandatory Immunization History Form

Last Name:	First Name:	MI:	Student ID#:
Address:	City:	State:	Zip:
Email:	Cell#:	Date of Birth:	

Section A: **REQUIRED IMMUNIZATIONS** (Required for ALL students born after 12/21/1956)

Vaccination	Month/Day/Year	Month/Day/Year	Month/Day/Year	Month/Day/Year
1. MMR (Measles, Mumps, Rubella) Two doses are required by the State of Florida for ALL students or proof of a positive Titer				Positive Titer: **please note that laboratory results must be attached**
Or **Measles** (two doses)				
And **Rubella** (one dose)				
2. Td (Tetanus) **or TDaP** (Tetanus, Diphtheria, and Pertussis) Td _____ or TDaP _____ (Please mark appropriately)	**must be within ten years**			
3. Hepatitis B *(vaccination required for all students residing in campus housing)*				Positive Titer: **please note that laboratory results must be attached**
	☐ I have read the information provided about Hepatitis B and I decline receipt of the vaccination. _____ Signature of Student (or) Parent if student under 18 years of age			
4. Meningitis/Menactra/MCV4 *(vaccination required for all students residing in campus housing)*		Booster needed if 1st dose given prior to age 16		
	☐ I have read the information provided about Meningitis and I decline receipt of the vaccination. _____ Signature of Student (or) Parent if student under 18 years of age			
5. Tuberculosis Screening (required for all students residing at an address outside the United States prior to six months of arrival to campus)	*Date of negative PPD screening* **Or N/A if non-international student**		***Date of negative CXR, if PPD positive*** **X-ray results must be attached**	

Section B (OPTIONAL): Recommended for good health but not required for admission to Saint Leo University

Vaccination	Month/Day/Year	Month/Day/Year	Month/Day/Year	Month/Day/Year
Hepatitis A				
Human Papillomavirus (HPV)				
Polio (OPV)/(IPV) **last dose only**				
Varicella (Chicken Pox)			*Year/History of disease*	Titer date (laboratory results must be attached)

Section C: Verification of Immunization Form

This signature/stamp verifies all vaccinations documented above. Verification of additional or missing vaccinations may be documented by submitting a signed/official document of immunization.

_____ _____ _____
Official Stamp/Seal of Medical Provider | Signature of Authorized Medical Provider | Date

Section D: Consent to Treat

Consent to Treat for Minors: I hereby authorize Saint Leo University to employ diagnostic procedures and render any treatment deemed medically necessary to the health and well-being of my minor child. I also grant permission, should the situation render necessary, that my child be transported to an accredited hospital by a licensed health care professional. In the event of an emergency, I authorize treatment of my child as deemed necessary by a licensed healthcare professional.

_____ _____
Signature of Parent/Guardian | Date

Consent to Treat: I hereby give my consent for medical treatment at the Health and Wellness Center of Saint Leo University. I understand that any services rendered to me by the nurses of the Health and Wellness Center are free of charge to me. I also understand that by utilizing the campus physician or ARNP, that there will be a charge to my student account, should I not elect the school issued insurance and that I will be responsible for those charges.

_____ _____
Signature of Student | Date