# Sample Immunization Form

**All dates should be entered in the same format: Month/Day/Year**

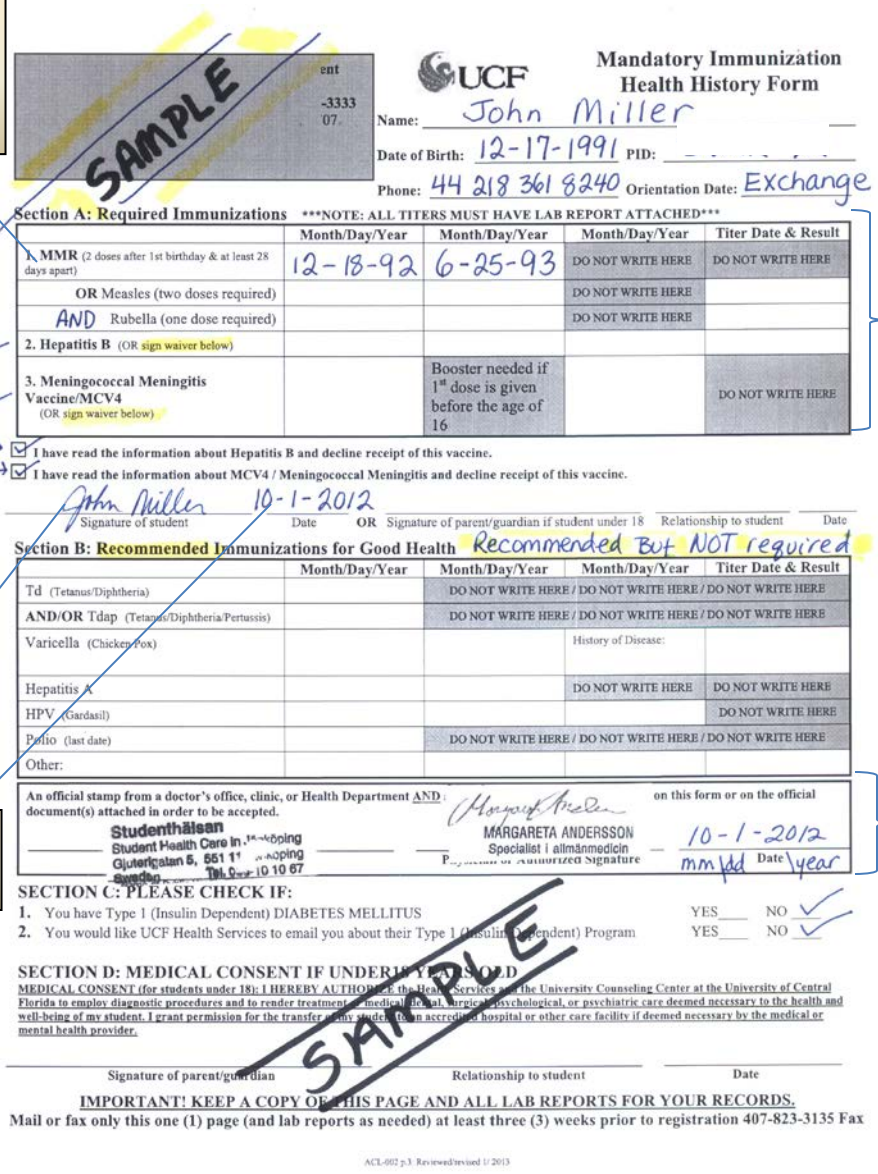
You MUST enter 2 dates for the MMR vaccine and they **MUST** fall within the guidelines.

Only Hepatitis and Meningitis can be waived. **NOT the MMR**

You **MUST** sign and date the form.

Section "A" is the only section that must be filled in, sections B – D are recommended but not required

**MUST** be signed, stamped and dated by an appropriate health provider.



SAMPLE

UCF **Mandatory Immunization Health History Form**

Name: John Miller

Date of Birth: 12-17-1991 PID:

Phone: 44 218 361 8240 Orientation Date: Exchange

**Section A: Required Immunizations** ***NOTE: ALL TITERS MUST HAVE LAB REPORT ATTACHED***

| | Month/Day/Year | Month/Day/Year | Month/Day/Year | Titer Date & Result |
|---|---|---|---|---|
| 1. MMR (2 doses after 1st birthday & at least 28 days apart) | 12-18-92 | 6-25-93 | DO NOT WRITE HERE | DO NOT WRITE HERE |
| OR Measles (two doses required) | | | DO NOT WRITE HERE | |
| AND Rubella (one dose required) | | | DO NOT WRITE HERE | |
| 2. Hepatitis B (OR sign waiver below) | | | | |
| 3. Meningococcal Meningitis Vaccine/MCV4 (OR sign waiver below) | | Booster needed if 1st dose is given before the age of 16 | | DO NOT WRITE HERE |

☑ I have read the information about Hepatitis B and decline receipt of this vaccine.

☑ I have read the information about MCV4 / Meningococcal Meningitis and decline receipt of this vaccine.

John Miller 10-1-2012

Signature of student Date OR Signature of parent/guardian if student under 18 Relationship to student Date

**Section B: Recommended Immunizations for Good Health** Recommended But NOT required

| | Month/Day/Year | Month/Day/Year | Month/Day/Year | Titer Date & Result |
|---|---|---|---|---|
| Td (Tetanus/Diphtheria) | | DO NOT WRITE HERE / DO NOT WRITE HERE / DO NOT WRITE HERE | | |
| AND/OR Tdap (Tetanus/Diphtheria/Pertussis) | | DO NOT WRITE HERE / DO NOT WRITE HERE / DO NOT WRITE HERE | | |
| Varicella (Chicken Pox) | | | History of Disease: | |
| Hepatitis A | | | DO NOT WRITE HERE | DO NOT WRITE HERE |
| HPV (Gardasil) | | | | DO NOT WRITE HERE |
| Polio (last date) | | DO NOT WRITE HERE / DO NOT WRITE HERE / DO NOT WRITE HERE | | |
| Other: | | | | |

An official stamp from a doctor's office, clinic, or Health Department AND on this form or on the official document(s) attached in order to be accepted.

Studenthälsan Student Health Care in Norrköping Gjuterigatan 5, 601 11 Norrköping Sweden Tel. 0 10 10 67

MARGARETA ANDERSSON Specialist i allmänmedicin

Physician or Authorized Signature 10-1-2012 mm/dd Date year

**SECTION C: PLEASE CHECK IF:**

1. You have Type 1 (Insulin Dependent) DIABETES MELLITUS YES___ NO ✓
2. You would like UCF Health Services to email you about their Type 1 (Insulin Dependent) Program YES___ NO ✓

**SECTION D: MEDICAL CONSENT IF UNDER 18 YEARS OLD**

MEDICAL CONSENT (for students under 18): I HEREBY AUTHORIZE the Health Services and the University Counseling Center at the University of Central Florida to employ diagnostic procedures and to render treatment (medical, dental, surgical, psychological, or psychiatric care deemed necessary to the health and well-being of my student. I grant permission for the transfer of my student to an accredited hospital or other care facility if deemed necessary by the medical or mental health provider.

SAMPLE

Signature of parent/guardian Relationship to student Date

IMPORTANT! KEEP A COPY OF THIS PAGE AND ALL LAB REPORTS FOR YOUR RECORDS.

Mail or fax only this one (1) page (and lab reports as needed) at least three (3) weeks prior to registration 407-823-3135 Fax

ACL-002 p.3 Reviewed/revised 1/ 2013

***** Incomplete or incorrect forms will be reject so be sure to follow the instructions.*****

- ***Ensure that the form is signed by all who needs to sign it.***
- ***MMR dates that fall outside of the guidelines will require you to get additional vaccinations.***
- ***If you are unsure about the other vaccination dates just simply check the waiver boxes.***