

Please Return To: Eckerd College Counseling & Health Services
4200 – 54th Ave. S., St. Petersburg, FL 33711 * Phone 727-864-8248

(All Forms Must Be In English)

CONFIDENTIAL STUDENT IMMUNIZATION FORM

Due: August 1, 2008

Registration will be delayed if this form is not returned prior to student's arrival on campus

Name: _____	<input type="checkbox"/> Male	<input type="checkbox"/> Female
First Name Preference: _____	Date of Birth _____	
Permanent Address: _____		
City, State, Zip: _____		
E-mail: _____	Student ID Number (if known): _____	
Parent/Guardian Name: _____		
Preferred Phone #: _____	Cell Phone #: _____	
Parent/Guardian Name: _____		
Preferred Phone #: _____	Cell Phone #: _____	
Admissions Status: <input type="checkbox"/> Freshman	<input type="checkbox"/> Transfer	<input type="checkbox"/> Non-Degree
<input type="checkbox"/> Exchange	<input type="checkbox"/> International	

Emergency Contact Information	
Name: _____	Relationship to You: _____
Preferred Phone #: _____	Work Phone #: _____

PLEASE INCLUDE COPY OF INSURANCE CARD

Insurance Identification should be carried at all times

Permission for Release of Medical Information and to Receive Medical Care

Permission for Release of Medical Information: I authorize the release of relevant medical information to my insurance company for the purpose of reimbursement.

Permission for Medical Care: I hereby grant permission to the Counseling Services and Health Services staff of Eckerd College to render any health care or emergency treatment according to standard practice to myself/son/daughter/ward.

Student's Signature: _____ Date: _____

If Student is under 18 years of age,
Parent/Guardian's signature: _____

IMMUNIZATION RECORD: Eckerd College
Must be completed prior to August 1! The registration process will be delayed for students not in compliance.

Full Name _____ Student ID or SS# _____

TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER
 ALL INFORMATION MUST BE IN ENGLISH

REQUIRED Immunizations

A. M.M.R. (Measles, Mumps, Rubella)

(Two doses required at least 28 days apart for students born after 1956)

Date Dose #1 / / Date Dose #2 / /
 M D Y M D Y

B. HEPATITIS B

(Three doses of vaccine or two doses of adult vaccine in adolescents 11-15 years of age, or a positive Hepatitis B surface antibody)

1. Immunization (Hepatitis B)

Date Dose # 1 / / Date Dose # 2 / / Date Dose # 3 / /
 M D Y M D Y M D Y

2. Hepatitis B surface antibody Date / / Result: Reactive
 M D Y Non-reactive

C. MENINGOCOCCAL VACCINE

(Vaccine date must be within 3 years)

Meningococcal conjugate Date / /
 M D Y

Recommended Immunizations and Tests

D. TETANUS-DIAPHTHERIA-PERTUSSIS

Date of Last Booster (within past 10 years) / / Completed Primary Series or
 M D Y Yes No

E. POLIO

a. Date of Last booster / / b. Completed Primary Series or
 M D Y Yes No

c. Vaccination Type : OPV alone IPV alone IPV/OPV Sequential

F. VARICELLA (Chicken Pox)

History of Disease or Immunization: Date Dose #1 / / Date Dose #2 / /
 Yes No M D Y M D Y

G. HUMAN PAPILOMAVIRUS VACCINE (HPV) (For female students 11-26 years of age)

Date of Dose # 1 / / Date of Dose # 2 / / Date of Dose # 3 / /
 M D Y M D Y M D Y

H. TUBERCULOSIS SCREENING: Provide copy of test and/or x-ray if positive

Tuberculosis Skin Test: Date Given / / Date Read / / : or
 M D Y M D Y Positive Negative

Certifying Health Care Provider's Information

Name _____ Address _____

Signature _____ Phone _____