Form 1

REQUIRED for New DE Students

THE FLORIDA STATE UNIVERSITY
UNIVERSITY HEALTH SERVICES
HEALTH & WELLNESS CENTER

STUDENT ADMISSIONS HEALTH HISTORY (Form 1)

YOU WILL NOT BE CLEARED TO REGISTER AT FSU WITHOUT THIS COMPLETED FORM
AND ADEQUATE PROOF OF IMMUNIZATIONS ON FILE

MAIL or FAX ALL COMPLETED PAGES TO:
University Health Services
Health Compliance Office
960 Learning Way
TALLAHASSEE, FLORIDA 32306-4178
Fax: 850.644.8958
Or Electronically submit using FSU drop box

THIS FORM REQUIRES FIVE DAYS FOR PROCESSING

Information:
healthcenter.fsu.edu
Insurance: 850.644.4250
Immunizations:850.644.3608

SECTION A -. PRINT TWO COPIES OF THIS FORM. SUBMIT ONE; KEEP THE OTHER FOR YOUR RECORDS.

PLEASE PRINT LEGIBLY (ILLEGIBLE FORMS WILL NOT BE PROCESSED)

NAME Last	First	Mi	DOB ___/___/___	FSU EMPLID	Sex F ...M	Race

Address	City	State	Zip

Home Phone:( )	Cell Phone:( )

Email Address:

Primary Care Physician:	Address	Phone/Fax

SECTION B–

Please list any relevant personal medical history: _____

Please list any relevant family medical history: _____

Do you have any allergies (to incl. medications): No Yes Please list if answered yes: _____

SECTION C -

PLEASE READ AND INITIAL EACH SECTION BELOW

Student Observers

_____I understand and acknowledge, by signing this document, that FSU Student Health and Wellness Center, as part of Florida State University, may have students from healthcare majors (i.e. College of Nursing, College of Medicine, College of Human Sciences) as observers during the course of my visit at UHS. I further understand that the UHS staff members will inform me when a student is observing my care. I give UHS permission to allow a student observer and I understand that I may at any time, decline to have a student observer during the course of my care at UHS.

Notice of Privacy Policy

_____I acknowledge, by my signature below that I have received a copy of the FSU Student Health and Wellness Center Notice of Privacy Practices (available at http://healthcenter.fsu.edu/forms/privacy_policy_2013.pdf) as required by Federal Regulations.

Consent to Treat

I authorize FSU Student Health and Wellness Center, its agents (ie College of Medicine, College of Nursing, First Responder Unit) and employees, to provide and perform such care, procedures, tests, and other services as are considered advisable by my clinician for my health and well being. I acknowledge that no guarantees have been made to me as to the effect of such examinations, procedures, and treatment of any condition.

Student Signature _____ **Date:** _____

REQUIRED AUTHORIZATION FOR CARE OF STUDENTS UNDER AGE 18: I CONCUR WITH THE ABOVE AND AUTHORIZE, AT THE DISCRETION OF HEALTH CENTER PERSONNEL, MEDICAL AND SURGICAL CARE INCLUDING EXAMINATIONS, TREATMENTS, IMMUNIZATIONS AND THE LIKE FOR MY SON/DAUGHTER. In the event of serious disease or injury or the need for major surgery, I understand that all reasonable effort will be made to contact me but the failure to make contact will not prevent emergency treatment if necessary to help preserve life or health.

Parent / Guardian signature _____ Date: _____

THE FLORIDA STATE UNIVERSITY

UNIVERSITY HEALTH SERVICES

HEALTH & WELLNESS CENTER

FAMU CO-OP/ Dual Enrollment Form

Part A—Print or type. Illegible forms will not be processed.

STUDENT NAME: Last _____First_____MI_____

DATE OF BIRTH: ____/___/_____ FSU EMPLID _____ Gender: ◯Male ◯Female ◯Other Race: _____

Home Phone: _____ Cell Phone: _____ E-mail: _____

Part B — To be completed by Clinician/Records custodian

BOTH IMMUNIZATIONS MUST BE COMBINED MMRs. SINGLE SHOTS ACCEPTABLE ONLY IF ADMINISTERED ON THE SAME DATE.

If your attached CO-OP/Dual Enrollment form has the required immunizations, the MMR dates do not have to be entered here. Make certain to bring Two copies of the FAMU record if you are from FAMU.

Part B **Dates Required**	**REQUIRED IMMUNIZATIONS**		
Combined MMR dates No single shots	Dose 1 / / On or after first birthday	Dose 2 / / At least 28 days later	Titers: document attached
Meningococcal Meningitis dates	Dose 1 / /	Dose 2, if applicable	
Meningococcal Meningitis	Waiver Student Initials _____	Date / / of waiver (REQUIRED)	
Hepatitis B dates	Dose 1 / /	Dose 2 / /	Dose 3 / /
Hepatitis B	Waiver Student Initials_____	Date / / of waiver (REQUIRED)	Titer: document attached

Waiver Information: I have received the required information regarding the risks of acquiring meningococcal meningitis and Hepatitis B and the benefits of receiving immunizations to reduce those risks. I also understand that I am required to receive these immunizations or to actively decline the immunizations by placing my initials in the space(s) **provided above**. I understand that I may decline either or both immunizations and that declining these vaccines now does not mean I may not receive them in the future. _____
patient signature

Part C: AUTHORIZATION and additional comments: The immunization dates and any statements of contraindication to immunizations entered on this document are, as of the date signed, verified by my signature below. Additional physician comments: _____

_____
Clinician or Records Custodian Name

_____ _____
Clinician or Records Custodian Signature Date Office Stamp

FAMU CO-OP/Dual Enrolled Immunization Record fax to 850-644-8958 or mail to 960 Learning Way, Tallahassee, FL 32306-4178