FLAGLER COLLEGE

OFFICE OF STUDENT SERVICES
HEALTH SERVICES

MEDICAL COMPLIANCE IMMUNIZATION FORM

MAIL FORM TO: FLAGLER COLLEGE, HEALTH SERVICES, 74 KING STREET, SAINT AUGUSTINE, FLORIDA 32084
PHONE: (904) 819-6211 FAX: (904) 824-1183

COMPLETION OF THIS FORM IS NECESSARY TO COMPLY WITH FLORIDA ADMINISTRATIVE CODE 6.001 (9) AND 6.007. YOUR REGISTRATION CANNOT PROCEED WITHOUT COMPLETION OF THIS FORM. AN OFFICIAL FORM FROM YOUR PHYSICIAN OR PUBLIC HEALTH CLINIC WILL BE ACCEPTED IN LIEU OF THIS FORM.

Name _____ Gender ☐ Male ☐ Female
LAST NAME (SURNAME) FIRST NAME (GIVEN NAME) MIDDLE NAME

ID Number _____ Cell phone _____ Birth date _____ Age _____
MONTH / DATE / YEAR

Month and year you plan to enter Flagler College ☐ September ☐ January Year _____

IMMUNIZATIONS REQUIRED OF ALL STUDENTS

MMR COMBINED (Measles, Mumps, and Rubella): Two doses will fulfill Flagler College's requirements.
First dose at 12 months old or later _____ Second dose at least 30 days after first dose _____
MONTH / DATE / YEAR MONTH / DATE / YEAR

OR

MEASLES (Rubeola): Positive blood IGG Titer (Lab results MUST be attached) _____
MONTH / DATE / YEAR
AND
RUBELLA (German Measles): Positive blood IGG Titer (Lab results MUST be attached) _____
MONTH / DATE / YEAR

HEPATITIS B: Series of three doses are required.

First dose _____ Second dose _____ Third dose _____
MONTH / DATE / YEAR MONTH / DATE / YEAR MONTH / DATE / YEAR

OR

Waiver of Liability: I acknowledge receipt and review of information supplied by Flagler College regarding Hepatitis B. I understand the risks involved, but elect not to receive the Hepatitis B vaccine.

Signature of student (or parent/guardian if under 18) _____ Date _____

MENINGITIS VACCINE CONFIRMATION DATE: _____
MONTH / DATE / YEAR
AND
BOOSTER (If 1st dose received before age 16): _____
MONTH / DATE / YEAR

OR

Waiver of Liability: I acknowledge receipt and review of information supplied by Flagler College regarding Meningitis. I understand the risks involved, but elect not to receive the Meningitis vaccine.

Signature of student (or parent/guardian if under 18) _____ Date _____

IMMUNIZATIONS REQUIRED OF INTERNATIONAL STUDENTS

TUBERCULOSIS (PPD test by mantoux or QuantiFERON-TB Gold In-Tube): Immunizations must be within the past year.

PPD Result: ☐ Negative ☐ Positive _____ QuntiFERON-TB Gold In-Tube Result: ☐ Negative ☐ Positive _____
MONTH / DATE / YEAR MONTH / DATE / YEAR

If positive PPD, chest x-ray is required. _____ Result _____
MONTH / DATE / YEAR

ALL DOCUMENTATION MUST INCLUDE THE SIGNATURE AND THE OFFICE STAMP OF THE HEALTH CARE PROVIDER.

Authorized or physician's signature _____ Date _____