Health Information Management Department

University of Central Florida

4098 Libra Drive, Orlando FL 32816-3333

PHONE: 407.823.3707/2119

http://www.studenthealth.ucf.edu/immunizations

Mandatory Immunization Health History Form

Name: _____

Date of Birth: _____ UCF ID: _____

Phone: _____ Orientation Date: _____

Section A: Required Immunizations

Required for all students born after 12/31/1956	Month/Day/Year	Month/Day/Year	Month/Day/Year	Titer Date & Result
1. **MMR** (2 doses after 1st birthday & at least 30 days apart in 1971 or later)			DO NOT WRITE HERE	Please attach lab report
OR Measles (two doses required given in 1968 or later)			DO NOT WRITE HERE	Please attach lab report
Rubella (one dose required given in 1969 or later)			DO NOT WRITE HERE	Please attach lab report
2. Hepatitis B (OR sign waiver below)				Please attach lab report
3. MeningococcalMeningitisVaccine/MCV4: (Menactra/Menveo) (must be given after the age of 16 OR sign waiver below)		Booster needed if 1st dose is given before the age of 16		DO NOT WRITE HERE

WAIVER: I have read the information provided about Hepatitis B and Meningococcal Meningitis/MCV4. By signing below, I acknowledge I am declining both, which are highly recommended, but not required.

_____ _____ **OR** _____ _____ _____

Signature of student | DATE | Signature of parent/guardian if student under 18 | Relationship to student | DATE

Section B: Recommended Immunizations for Good Health (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		
Meningococcal B Serogroup (Bexsero/Trumenba)				
Covid-19 (Johnson & Johnson, Moderna, Pfizer)				

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

_____ _____ _____

Official Stamp Here | **Physician or Authorized Signature** | **Date**

SECTION C: Type 1 Diabetes

Do you have type 1 Diabetes? If yes, please enter your student email to receive information about the student support group?

Email Address _____

SECTION D: MEDICAL CONSENT IF UNDER 18 YEARS OLD

I HEREBY AUTHORIZE Student Health Services and the University Counseling Center at the University of Central Florida to employ diagnostic procedures and to render treatment or 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 and for my student to sign any necessary consents.

_____ _____ _____

Signature of parent/guardian | **Relationship to student** | **Date**