EMAIL: **health.center@saintleo.edu**
FAX: (352) 588-8305
MAIL: Saint Leo University Health Center
P.O. Box 6665, MC 2214
Saint Leo, FL 33574

SAINT LEO UNIVERSITY
Health Center

Mandatory Immunization Form

REQUIRED – SLU ID NUMBER (7 digits):

☐☐☐☐☐☐☐

Name:_____ **First Term of Attendance: ☐ FALL ☐ SPRING ☐SUMMER**

Date of Birth:_____ **Phone:** _____

SECTION A: Required Immunizations

Vaccine Name	Date (MM/DD/YYYY)	Date (MM/DD/YYYY)	Date (MM/DD/YYYY)	Titer Date & Result (If no vaccine dates available-Must include lab report)
1. MMR (Measles, Mumps, Rubella) (2 doses on or after 12 months of age)			--NOT APPLICABLE--	
2. Hepatitis B (3 doses OR check decline box)				
☐ I have read the information about Hepatitis B and decline receipt of this vaccine. Student or Guardian Signature _____ Date _____				
3. MCV4 (Menactra/Menveo) **One dose after 16th birthday OR check the decline box**			--NOT APPLICABLE--	
☐ I have read the information about MCV4 (Menactra/Menveo) / Meningococcal Meningitis and decline receipt of this vaccine. Student or Guardian Signature _____ Date _____				

4. Tuberculosis Screening (Required for International Students) ***Must have completed testing 6 months prior of arrival to campus***				
TB Skin Test by TST (Mantoux)	Date Placed	Date Read	MM	**Result:** Neg Pos
OR Interferon-based Assay (QFT or Tspot)	Date	Result	**Submit copy of lab report in English**	
Chest X-ray **(Only if positive TST or Lab Test)**	Date	Result	**Submit copy of x-ray report in English**	

SECTION B: Optional Immunizations – Not Required

Td/Tdap			--NOT APPLICABLE--		
Varicella (Chickenpox)				--NOT APPLICABLE--	
Hepatitis A					
HPV (Gardasil or Cervarix)					--NOT APPLICABLE--
COVID-19	Moderna/Pfizer/ J&J			--NOT APPLICABLE--	
Meningitis B	Bexsero			--NOT APPLICABLE--	
	Trumenba				--NOT APPLICABLE--

An official stamp from a doctor's office, clinic or health department AND an authorized signature must appear here or a complete immunization history from your physician or this form will not be approved.

_____ _____ _____

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