



HEALTH CENTER
 12180 Park Avenue South
 Tacoma, Washington 98447-0003

Phone: 253-535-7337
 Fax: 253-536-5042
 Email: health@plu.edu

Student Immunization History and Emergency Information <i>THIS FORM IS REQUIRED FOR ATTENDANCE</i>			Documents may be sent securely via fax or through our secure ETRIEVE site: https://etcentral.plu.edu/#/form/24	
PACIFIC LUTHERAN UNIVERSITY OFFERS MEDICAL SERVICES TO ALL STUDENTS, FULL OR PART TIME.				
Last Name		First Name		Middle Initial
Preferred Name				
Date of Birth (MM/DD/YYYY)	Gender Assigned at Birth <input type="checkbox"/> Female <input type="checkbox"/> Male	Gender Identity <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Trans <input type="checkbox"/> Nonbinary <input type="checkbox"/> Other:		Social Security Number
PLU Student ID	Telephone Number (Home)		Telephone Number (Mobile/Cell)	
HOME ADDRESS				
Street		City	State or Province	ZIP or Postal Code
Country				
Name of Emergency Contact (in U.S.)		Emergency Contact Telephone Number		Emergency Contact Relationship
Are you an International Student?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, which country are you from?		
Which program are you enrolled in?	<input type="checkbox"/> Undergrad <input type="checkbox"/> Visiting Scholar	<input type="checkbox"/> International program <input type="checkbox"/> Pathway International	<input type="checkbox"/> MBA	
Are you a former PLU student?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what year did you attend?		
In what term will you enter PLU?	<input type="checkbox"/> Fall <input type="checkbox"/> J-Term <input type="checkbox"/> Spring <input type="checkbox"/> Summer	What was your previous last name?		
Of which year?	In (YYYY):			
INSURANCE INFORMATION				
Do you have medical and hospital coverage?		<input type="checkbox"/> Yes <input type="checkbox"/> No	PLEASE ATTACH A COPY (FRONT & BACK) OF YOUR INSURANCE CARD	

1. Health Center Consent and Release	<i>This document has legal significance - please read it carefully.</i>
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Pacific Lutheran University (PLU) will keep your medical records confidential, and they will only be used for the provision of health care services. Because of PLU's promise of confidentiality, you, as the student, must inform Residence Hall staff or other university personnel (i.e. physical education instructors or athletic coaches) of any medical condition that you have that could be of concern while you are attending PLU. Furthermore, you are responsible for wearing a Medic Alert bracelet, necklace, or similar device to warn health care providers of your diabetes, hemophilia, heart disease, seizure disorder, drug allergies, or other significant medical conditions.

In the event that PLU is required to rely on this consent to authorize necessary medical care and treatment for the student, the undersigned, individually and jointly, agree to indemnify and hold PLU harmless for the costs incurred for said emergency care and treatment, including reasonable attorney's fees and costs incurred in defending and/or instituting a suit to recover said medical expenses.

As a PLU student, I consent to any necessary medical or surgical treatment in the event of a medical emergency as confirmed by any attending physician, advanced registered nurse practitioner, or physician assistant at PLU Health Services. If the student is under 18 years of age, PLU will attempt to contact the undersigned parent or guardian for approval before relying on this consent. In addition, the undersigned student must personally consent to said medical procedure if he or she is physically and emotionally capable of consenting at the time such treatment is required.

Student Signature	Please Print Name	Date
Parent or Guardian <i>Signature Required if the student is under 18 years of age</i>	Please Print Name	Date

Last Name	First Name	Middle Initial	Student ID

2. Immunization Record - You may also attach copies of vaccines or lab results as official records.

**** You will not be permitted to register for classes without proof of 2 MMR's and, as of 4-26-21, COVID vaccines or COVID Exemption form.**

COVID and MMR Exemption forms can be located on our website www.plu.edu/chws/documents under "Health Forms"

- Places to look for official immunization documents include your high school, primary care provider's office, parent's official records, your Public Health Department, and military records.
- If you are unable to locate this information, we are able to offer you titer blood draws at the Health Center at a reduced cost. Please call the Health Center at 253-535-7337.
- If you were born **prior to 1 January 1957**, you are considered immune to the MMR due to exposure to these diseases, and you are not subject to the immunization requirements.
- **For all other students:**
 - A. **Rubeola (Measles)** - One of the following must be provided:
 1. Documentation of two immunizations with live attenuated virus vaccine after the student's first birthday and administered at least 30 days apart. Persons vaccinated with an inactivated (killed) virus or an unknown vaccine prior to 1968 must be revaccinated.
 2. Documented history of measles disease.
 3. Documented laboratory evidence of immunity to rubeola.
 - B. **Mumps** - One of the following must be provided:
 1. Documentation of immunization after 1967 and after the student's first birthday.
 2. Documented history of mumps disease.
 3. Documented laboratory evidence of immunity to mumps.
 - C. **Rubella (German Measles)** - One of the following must be provided:
 1. Documentation of vaccination with a live virus vaccine after 1969 and after the student's first birthday.
 2. Laboratory evidence of immunity to rubella.

REQUIRED IMMUNIZATIONS FOR ALL STUDENTS:

Measles, Mumps, and Rubella (MMR)	Date of 1st Vaccine	OR	Measles	Date of 1st Vaccine	
	Date of 2nd Vaccine			Date of 2nd Vaccine	
OR MMR Titer results	<input type="checkbox"/> Positive <input type="checkbox"/> Negative		Mumps	Date of Vaccine	
	Date of Titer:		Rubella	Date of Vaccine	
COVID-19	Date / Name of 1st Vaccine		Date / Name of 2nd Vaccine		

Signature of Healthcare Provider

MA DO LPN
 RN NP/ARNP MD

Telephone Number

Date

RECOMMENDED IMMUNIZATIONS FOR ALL STUDENTS

Tetanus	<input type="checkbox"/> Td <input type="checkbox"/> TdAP	Hepatitis B 1	Hepatitis B 2	Hepatitis B 3
Date of Last Vaccine		Date of 1st Vaccine	Date of 2nd Vaccine	Date of 3rd Vaccine
Hepatitis A 1	Hepatitis A 2	HPV 1	HPV 2	HPV
Date of 1st Vaccine	Date of 2nd Vaccine	Date of 1st Vaccine	Date of 2nd Vaccine	Date of 3rd Vaccine
Adult Polio (OPV/IPV)	Varicella (Chickenpox)	Meningococcal (MCV)	MEN B	
Date of Vaccine	Date of 1st Vaccine Date of 2nd Vaccine	Date of 1st Vaccine	Date of 1st Vaccine	
	<input type="checkbox"/> Disease <input type="checkbox"/> Titer	Date of 2nd Vaccine	Date of 2nd Vaccine	
COVID-19 Booster	Date / Name of 1st Booster		Date / Name of 2nd Booster	