PLEASE PRINT NEATLY

Health Services Ext. 2341

OUR LADY OF THE LAKE UNIVERSITY 411 S.W. 24TH STREET • SAN ANTONIO, TEXAS 78207 • 210-434-6711

Last Name _____ First _____ M.I. _____

Birth Date ___/___/_____ Social Security # _____ Country of Birth _____

Permanent Address _____
Street City State Zip

Home Phone _____ Cell Phone _____

Local Address _____
Street / Campus Box Number City State Zip

Local Phone or Residence Ext. _____ Location _____
Residence Hall and Room Number

☐ Faculty ☐ Staff ☐ Student ☐ Dependant _____
Parent / Guardian Name

☐ Undergraduate Studies ☐ Graduate Studies ☐ Extended Learning (WEC)

The following information is required of all students. (Provide at least month and year):

TETANUS/DIPTHERIA (booster within the past 10 years): **TD** or **DT** Date ____/____/_____

MEASLES, MUMPS, RUBELLA (2 doses required of all entering students born after Jan. 1, 1957):

M.M.R. Dose 1 Date _____/_____/_____ Dose 2 Date _____/_____/_____

(or given as separate vaccines):

Measles Vaccine (2 dose required):

Dose 1 Date _____/_____/_____ Dose 2 Date _____/_____/_____

Or **Measles Disease** Date _____/_____/_____

Mumps Vaccine Date _____/_____/_____ or **Mumps Disease** Date _____/_____/_____

Rubella Vaccine Date _____/_____/_____ or **Rubella Titer** Date _____/_____/_____

From all students 18 or younger: Polio Series Completion Date _____/_____/_____

Physician's Signature _____
City State Zip

Or Verification by Health Care Provider

CDC (Center for Disease Control) Update from October 20, 1999 Press Release:

"The Advisory Committee on Immunization Practices (ACIP) has modified its guidelines for use of the polysaccharide meningococcal vaccine to prevent bacterial meningitis, particularly for college freshman who live in dormitories, a group found to be at a modestly increased risk of meningococcal disease relative to other persons their age."

Meningococcal Vaccine Date _____/_____/_____ Physician's Signature _____

In addition to the above, all International Students must complete the following:

☐ PPD (Mantoux) Test within the past year. (Tine or Monovac – NOT ACCEPTABLE!)

Date _____/_____/_____ Positive _____ Negative _____

☐ Positive PPD – Chest X-Ray required.

Date _____/_____/_____ Positive _____ Negative _____

Parent/Guardian Authorization for all patients under 18 years of age:

I authorize Sarah Gormican, FNP and the Office of Health Services at Our Lady of the Lake University to administer medical services and therapeutic procedures as deemed necessary for the treatment of my child or dependant.

_____ Date _____/_____/_____
Parent/Guardian Signature