PALM BEACH ATLANTIC UNIVERSITY

HEALTH AND WELLNESS

Immunization Form

Last Name _____ First Name _____

PBA ID# _____

Birthdate: _____/_____/_____ Current Age: _____

Check all that apply:
❑ FT Undergraduate ❑ Part-Time/Evening ❑ Graduate
❑ Resident ❑ Commuter ❑ Nursing ❑ Pharmacy
❑ International

First term/year of PBA enrollment:
❑ Fall _____ ❑ Spring _____ ❑ Summer_____

TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER
Please document ALL vaccines received even if not required.

REQUIRED for	VACCINE or TEST	Date MM/DD/YY	Notes/Titer Dates
ALL Full-Time undergraduates born after 1956 **List all dates if given separate**	Measles, Mumps, Rubella #1 (MMR1)		or Positive Titer Dates Measles_____
	Measles, Mumps, Rubella #2 (MMR2)		Mumps_____ Rubella_____
Additional requirements for students living on campus **Per Florida Statute 1006.69 resident students must receive these vaccines or decline.***	Hepatitis B #1 (Hep B 1)		or Positive Titer Date _____ #3 not needed if 2-dose series given. Please indicate "2 dose" if applicable
	Hepatitis B #2 (Hep B 2)		
	Hepatitis B #3 (Hep B 3)		
	Meningococcal (ACWY) #1		#2 recommended if #1 was given before age 16
	Meningococcal (ACWY) #2		

***Sign below if you are choosing to decline the following vaccines:**

❑ I have read the information about Hepatitis B and decline the **Hepatitis B vaccine.** (www.cdc.gov/vaccines)

_____ _____
Signature of student or parent/legal guardian if under 18 years of age — Date

❑ I have read the information about Meningococcal Meningitis and decline the **Meningitis vaccine.** (www.cdc.gov/vaccines)

_____ _____
Signature of student or parent/legal guardian if under 18 years of age — Date

Recommended	VACCINE	Date MM/DD/YY	VACCINE	Date MM/DD/YY
Not required, but please document if vaccines were received.	Varicella #1		HPV #1	
	Varicella #2		HPV #2	
	Td		HPV #3	
	Tdap		TB TESTING PPD Skin Test	Date _____ Measurement _____mm
	Meningococcal (MenB) #1			
	Meningococcal (MenB) #2			
	Meningococcal (MenB) #3		TB Chest X-Ray	Date _____ Result _____
	Hepatitis A #1			
	Hepatitis A #2			
	Typhoid		IGRA Blood Test	Date _____ Result _____
	Yellow Fever			

NOTE: School of Nursing and School of Pharmacy may have additional requirements

PROVIDER OFFICE STAMP-*Mandatory*

_____ _____
Provider Signature — Date

_____ _____
Print Name — Phone

Please return form to PBA Health and Wellness Center • P.O. Box 24708 • West Palm Beach, FL 33416-4708
Email: Health_Wellness@pba.edu • Fax (561) 803-2499 • Phone (561) 803-2576