



SACRED HEART UNIVERSITY

UNIVERSITY COLLEGE

STUDENT HEALTH SERVICES

INSTRUCTIONS FOR STUDENTS:

1. Complete **Section I** of the form
2. Have a physician complete **Section II**
3. Return this form to:
Sacred Heart University, Health Services, 5151 Park Avenue, Fairfield, CT 06825

SECTION I

LAST NAME (Please Print)	FIRST NAME	M.I.	D.O.B.	SS#
HOME ADDRESS	CITY OR TOWN	STATE	ZIP	PHONE
PARENT / GUARDIAN NAME	ADDRESS (if different from above)			PHONE

SECTION II

This section **MUST** be completed by either a physician or nurse.

VACCINE Born after 1/1/57	1 st Dose after 1/1/69	2 nd Dose after 1/1/80	Lab Evidence of immunity (only if vaccine dates N/A) Accompanied by Laboratory Report	
			Date of test	Result of test
MMRs or MEASLES MUMPS RUBELLA				

Current Medications: _____

Drug Allergies: _____

Other Allergies: _____

Doctor's signature/stamp: _____ Phone: _____