Dear Student:

Welcome to Santa Fe University of Art & Design! We are glad you have chosen us to meet your higher education goals. Please complete and return the attached immunization and medical forms. SFU requires a complete immunization record for all students.

GUIDELINES FOR COMPLETING IMMUNIZATION RECORD

IMPORTANT – According to Santa Fe University of Art and Design policy, the immunization requirements must be met on or before your arrival on campus (you may bring documents with you at orientation; however, you will not be able to attend class or move into your campus residence without all documents.)

Acceptable Records of Your Immunizations: Be certain that your name, date of birth, and ID number appear on each sheet and that all forms are mailed together. The records must be in black ink and the dates of vaccine administration must include the month, day and year. All records must be in English. Please keep a copy for your records.

Personal Shot Records – Must be verified by a doctor’s stamp or signature or by a clinic or health department stamp.

IMMUNIZATION REQUIREMENTS STATED ON THIS FORM MUST BE COMPLETED AND ON FILE AT STUDENT HEALTH CENTER OFFICE BEFORE YOU ARRIVE ON CAMPUS

1. Complete the immunization form and return it by mail
2. Be certain to include your full name and Student ID number
3. Page 1 is a list of mandatory immunizations. Have your physician or Health Department clinician fill in your immunization record and update any needed immunizations that are required. This form must be signed a MD, PA, PA-C, FNM, FNP-C or stamped by the health department
4. In order to avoid excessive waiting times please have all of your immunization requirements completed and returned to Santa Fe University of Art & Design, Student Life Office, 1600 St. Michaels Drive, Santa Fe, New Mexico 87507 prior to your orientation date. The Student Health Center does not provide required vaccines on campus.
5. Page 2 is your Medical Release Form
6. Page 3 is for exemptions/waiver to meningococcal vaccine.

If you have any questions, please contact Student Life at 505-473-6270.

Making Healthy Choices Simple
TO BE COMPLETED BY STUDENT'S PRIMARY CARE PROVIDER:

Student’s Name:_________________________________________ Date of Birth:__________________

Student’s Address:__________________________________________________________________________

IMMUNIZATION RECORD

Required: to be completed and signed by your health care provider or attach copy of records

Meningococcal (required). Date ___/___/___ (Menactra conjugate preferred) **
Hepatitis B (recommended 3 doses). Date ___/___/___, ___/___/___, ___/___/___
Polio Series Completed. Date ___/___/___ or Adult Booster

CHRONIC CONDITIONS: ______________________________________________________________________

ALLERGIES TO MEDICATIONS:________________________________________________________________

Physical Examination:

BP_______  Pulse_______  Height_______ Weight_______
Corrected vision: Right 20/__  Left 20/__

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<thead>
<tr>
<th>Normal</th>
<th>System Examined:</th>
<th>Abnormalities</th>
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<tbody>
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<td>Neurologic</td>
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</tbody>
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PRIMARY CARE PROVIDER’S SIGNATURE______________________________ DATE____________

Print Name:_________________________________ Telephone Number (   )________________________
Fax number_________________________________ Address:___________________________________
Email Address_______________________________ City, State__________________Zip Code________
Dear Student:

Information provided on this form is confidential and will not be released to anyone without the student’s written consent. Please sign the Emergency Medical Authorization and General Consent, which are necessary to enable us to provide your health care, or, if you are under 18, please have your parents sign.

Emergency Medical Authorization
In case of emergency, if I (we) cannot be reached, I (we) give my (our) consent for the Senior Director of Student Life, Director of Campus Life or Nurse Practitioner of Santa Fe University of Art & Design, New Mexico, to authorize the health care provider in charge of this case, and the hospital to which the case of

____________________________________________________________________
Name of Student

Is taken to administer any treatment, including blood transfusions, and to administer such anesthetics, and to perform such operations as may be deemed medically necessary in the diagnosis and treatment of the above named person.

____________________________________________________________________
Student’s date of birth

____________________________________________________________________
Student signature if age 18 or over

____________________________________________________________________
Witness

____________________________________________________________________
Parent or Guardian if student under 18

____________________________________________________________________
Date

Consent to communication of medical information
I authorize the Health Center clinicians to communicate information about my condition as to specialists as necessary to diagnose and treat my medical conditions, to diagnostic laboratories as needed to perform testing and to other Health Center clinicians as necessary to care for me and to monitor and improve the quality of care.

____________________________________________________________________
Student signature if age 18 or over/Parent if student is under 18 years

____________________________________________________________________
Date

Contact information
In case of emergency, notify (parent, guardian or spouse):
Name__________________________ Relationship_______________________
Home Address)_________________________________________ City, State_________________________ Zip code_____________________
Home phone ( )__________________ Business Phone ( )___________ Cell phone ( )_____________________

Student’s primary care provider:
Name__________________________ Address:____________________________ Phone: ( )__________

Student’s health insurance:
Company:______________________ Address:____________________________ Phone: ( )__________

STUDENT’S CELL PHONE #______________________________________
MENINGOCOCCAL VACCINE REQUIREMENT

I have received the meningococcal vaccine as required by COLLEGE OF SANTA FE.
**DOCUMENTATION FROM A PHYSICIAN OR HEALTH CLINIC IS ATTACHED**

[Signature]

Print Name __________________________________________________________________________

Signature of individual 18 years of age or older  Date

Signature of parent or guardian of individual under 18  Date

Waiver of Vaccination

Individuals 18 or older may sign this Waiver choosing not to be vaccinated against meningococcal disease. For individuals under 18, a parent or guardian must review information on the risk of disease and sign that he or she has chosen not to have the individual vaccinated against meningococcal disease.

Individual 18 years of age or older:

I have received the information provided on the risk of meningococcal disease and the effectiveness and availability of the vaccine. I understand that meningococcal disease is rare, but life threatening illness. I understand Santa Fe University of Art & Design requires meningococcal vaccination for students unless I sign a waiver to the vaccination. I understand risks of not receiving the vaccine.

By signing below, I am indicating that I choose to waive receipt of meningococcal vaccination.

[Signature]

Print Name __________________________________________________________________________

Signature of individual  Date

Individual under the age of 18:

I have received information on the risks of meningococcal disease and the effectiveness and availability of the vaccine. I understand that meningococcal disease is a rare, but life threatening illness. I understand Santa Fe University of Art & Design requires meningococcal vaccination unless I sign a waiver to the vaccination. I understand risks of not receiving the vaccine.

I choose to waive receipt of meningococcal vaccine for my child.

[Signature]

Print name of child ___________________________________________________________________

Signature of parent or guardian  Date