ECKERD COLLEGE

Return this completed form before June 27, 2025.

Name: _____ Date of Birth: _____/_____/_____
mm/dd/yyyy

Eckerd ID#: _____ Phone:_____

Eckerd College Immunization Policy:

Eckerd College believes the entire college community is best served when every student is immunized. According to the Centers for Disease Control and Prevention, most vaccine-preventable diseases are spread from person to person. If one person in a community gets an infectious disease, that person can spread it to others who are not immunized. The more people who are immunized, the fewer opportunities a disease has to spread.
For the safety of our students and our campus, new students will not be allowed to move into residence halls, participate in athletics (including tryouts, practices, or competitions), or start classes prior to obtaining the following immunizations as recommended by the **American College Health Association**

For more information regarding Eckerd College's Immunization Policy please go to Immunization Policy

	REQUIRED IMMUNIZATIONS			****Titer****
	Month/Day/Year	Month/Day/Year	Month/Day/Year	Month/Day/Year
A. MMR (Measles, Mumps, Rubella)	1	2	Do not write here	Titer: Submitted dated lab report
	Two (2) doses if born in 1957 or later or lgG titer. Titer date & result of vaccines: Attach Quantitative Lab Report done within last 5 (five) years			
B. Hepatitis B	1	2	3	Do not write here
	If Hepatitis B immune, date of titer (must provide copy of results:			___/___/_____.
C. Meningitis MCV4/MenACWY	1	Do not write here		
	One (1) dose required at 16 years of age or older. **Booster required if dose given before the age of 16 years old			
D. Tetanus-Diptheria-Pertussis	1	Do not write here		
	One (1) does required within the past 10 years			
E. Varicella (Chicken Pox)	1	2	Do not write here	History of disease (circle)? Y or N
	Two (2) doses required OR history of the disease			___/___/_____.

F. Tuberculosis Screening	**Tuberculosis Screening** Tuberculosis Screening is required for all students who use an international address at the time of application. Screening must be done within 6 months prior to the semester start date.			
TB skin test by PPD Mantoux Must be read 2-3 days after injection	**Date Placed:**	**Date Read:**	**MM** indication of millimeters	**Result (circle)**: Positive or Negative
OR Blood Test/Lab QFT only	**Date:**	**Result:**	Submit Copy of Lab Report	
OR Chest X-ray if positive PPD or QFT	**Date:**	**Result:**	Submit physician-signed chest X-ray report	

	RECOMMENDED IMMUNIZATIONS (NOT REQUIRED)			
	Month/Day/Year	Month/Day/Year	Month/Day/Year	Month/Day/Year
G. Human Papillomavirus (HPV)	1	2	3	Do not write here
	Do not write here			
H. Hepatitis A	1	2	Do not write here	Do not write here
	Do not write here			
I. Pneumococcal	1	Do not write here		
J. Polio	1	Do not write here		Completed primary series (circle)? Y or N
K. Coronavirus	1	2	Booster:	Do not write here
	Do not write here			
L. Influenza (Flu)	**Recommended annually as soon as it becomes available			

An official stamp from a doctor's office, clinic, or Health Department **AND** an authorized signature must appear on this form or on the official document(s) attached in order to be accepted.

_____ _____

Official Office Stamp Here Physician or Authorized Signature Date ___/___/____

Permission for Release of Medical Information: I understand that this information may be shared with Florida Medical Clinic in the event it is needed for medical care.

Student's signature: _____ Date: _____

If student is under 18 years of age,
Parent/guardian signature: _____ Date: _____