



**UNF**  
UNIVERSITY of  
NORTH FLORIDA

**STUDENT HEALTH SERVICES MEDICAL COMPLIANCE IMMUNIZATION FORM**

**IMPORTANT**  
**COMPLETION OF THIS FORM IS NECESSARY TO COMPLY WITH FLORIDA ADMINISTRATIVE CODE 6.001 (9) and 6.007. YOUR REGISTRATION CANNOT PROCEED WITHOUT COMPLETION OF THIS FORM.**

Student ID \_\_\_\_\_

Email Address \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_ Birthday (month/day/year) \_\_\_\_\_ Sex \_\_\_\_\_ YEAR: \_\_\_\_\_

For which term are you applying? SPRING SUMMER FALL

**INTERNATIONAL STUDENTS ONLY STATEMENT OF GOOD HEALTH**

Are you an international student on an F1, F2, J1 or J2 Visa? (Please circle) YES or NO

Please have your Medical Provider sign this statement of good health  
I \_\_\_\_\_, (physician name) attest to the best of my knowledge that the above named student is in good physical and mental health to attend courses at the University of North Florida.

PPD results \_\_\_\_\_ and/or Chest X-Ray result pos neg  
If needed, treatment completion date \_\_\_\_\_

Physician Signature \_\_\_\_\_ Address Stamp Required \_\_\_\_\_

**RETURN THIS FORM TO: UNF MEDICAL COMPLIANCE**  
**1 UNF DRIVE Jacksonville FL 32224**  
**TEL: 904 620-2175 FAX 904 620-2901**  
**ALL DOCUMENTATION MUST INCLUDE THE SIGNATURE AND THE OFFICE STAMP OF THE HEALTH CARE PROVIDER.**

**MMR Combined (Measles, Mumps and Rubella): Two doses required**

\_\_\_\_ / \_\_\_\_ / \_\_\_\_ 1st dose received after 12 months of age in 1968 or later.  
Month Day Year

\_\_\_\_ / \_\_\_\_ / \_\_\_\_ 2nd dose received 30 days or more after the 1st dose  
Month Day Year

(OR)

**Measles Titer**

\_\_\_\_ / \_\_\_\_ / \_\_\_\_ Positive Blood IGG Titer (Lab results MUST be attached).  
Month Day Year

AND

**Rubella Titer**

\_\_\_\_ / \_\_\_\_ / \_\_\_\_ Positive Blood IGG Titer (Lab results MUST be attached)  
Month Day Year

**Meningitis Vaccine Confirmation date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

or

Waiver of Liability: I acknowledge receipt and review of University supplied information regarding Meningitis. I understand the risks involved, but elect not to receive the Meningitis vaccine.

Signature of Student or (parent/legal guardian, if under 18 years) \_\_\_\_\_ Date \_\_\_\_\_

**Hepatitis B Vaccine Confirmation dates:** 1st dose \_\_\_\_ / \_\_\_\_ / \_\_\_\_ 2nd dose \_\_\_\_ / \_\_\_\_ / \_\_\_\_ 3rd dose \_\_\_\_ / \_\_\_\_ / \_\_\_\_

or

Waiver of Liability: I acknowledge receipt and review of University supplied information regarding Hepatitis B. I understand the risks involved, but elect not to receive the Hepatitis B vaccine.

Signature of Student or (parent/legal guardian, if under 18 years) \_\_\_\_\_ Date \_\_\_\_\_

**PHYSICIAN SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_  
**OFFICE STAMP MANDATORY**

