

UNIVERSITY OF NEBRASKA

Pre-Enrollment Health Requirement

Name: Last	First	Middle	Date of Birth	NU Student ID Number
Local Address		City, State, Zip		Contact Phone Number
Permanent Address		City, State, Zip		Email Address

REQUIRED IMMUNIZATIONS FOR ALL UNIVERSITY OF NEBRASKA STUDENTS

I understand I am required to submit a copy of previous immunizations (i.e. school record or from your healthcare provider).

Rubeola Measles Immunity

_____ First MMR (measles mumps rubella). Must be after first birthday and 1-1-1968.
Month Day Year

_____ Second MMR (measles mumps rubella). No sooner than 30 days after first MMR.
Month Day Year

OR

_____ Blood test for Rubeola Measles. A copy of the test results is required and must be attached to this form.
Month Day Year

OR

Born before January 1, 1957 (You do not have to submit records or additional information.)

Students not actually taking classes on campus (distance students) do not need to complete the form until a class is taken on campus.

I am a Full Time UNL employee. Attach a copy of your Firefly Allocation Confirmation printout. (Website: <https://firefly.nebraska.edu/>)

Signature of Parent or Student or Licensed Care Provider _____ Date _____

REQUIRED OF INTERNATIONAL STUDENTS

- All new international students are required to have a test for tuberculosis done at the University of Nebraska when they arrive on campus.
- If your test for tuberculosis is positive, you will be required to have a chest x-ray.

MENINGOCOCCAL Nebraska state law requires postsecondary institutions to provide students and parents information related to meningococcal disease.

I have read the information on Meningococcal disease. (Website: www.cdc.gov/meningitis/index.htm)

Yes, I have been vaccinated. _____ No, I have not been vaccinated
Month Day Year

PARENT/GUARDIAN MUST SIGN BELOW FOR AUTHORIZATION CARE FOR STUDENTS UNDER 19 YEARS OLD

Authorization for Treatment of a Minor

I authorize the University Health Center, University of Nebraska – Lincoln to provide medical and/or mental health care to
Student Name _____ NU ID# _____

Services may include but are not limited to diagnostic examinations (including laboratory and radiological testing), verification and/or administration of immunizations, and necessary medical treatment including minor surgical procedures and mental health counseling. I understand that should my minor child need more invasive diagnostic or surgical procedures, attempts will be made to contact me before such care is initiated.

I further understand, according to Nebraska law, that once the above named minor reaches age 19 my consent for treatment is no longer required. Parental/guardian consent is not legally required for minors who seek medical diagnosis and treatment for sexually transmitted diseases.

Signature: Parent Guardian _____ Print Name _____ Date Signed _____