University Health Center
University of Maryland
College Park, MD 20742
Upload form to **myuhc.umd.edu**

DIVISION OF STUDENT AFFAIRS
UNIVERSITY HEALTH CENTER

Immunization questions or information:
301-314-8114

IMMUNIZATION RECORD

Please submit your immunization information by orientation

TO BE COMPLETED BY ALL STUDENTS. PLEASE PRINT LEGIBLY IN BLUE OR BLACK INK.

Name (Last) First

University ID# Date of Birth (mm/dd/yyyy)

Citizen Status: (circle one) US Citizen Permanent Resident International

What is your home country?

Cell Phone Number: Email Address:

Parental/Guardian Consent (for students under age 18) I give permission for such diagnostic and therapeutic procedures as may be deemed necessary for my student until they turn 18. The Health Center will seek to notify parents in the event of an emergency.

Signed Relationship Date

SECTION A (REQUIRED): ALL STUDENTS BORN AFTER 1956 MUST PROVIDE THIS INFORMATION

Vaccines	Dates Given/Performed	Requirements
MMR	Dose 1_____/_____/_____ (mm dd yyyy) Dose 2_____/_____/_____ (mm dd yyyy)	2 doses of MMR −At least 4 weeks between doses −First dose given after 1st birthday −Second dose after age 4
OR		OR
Individual Vaccines: **−Measles** **−Mumps** **−Rubella**	**Measles** Dose 1_____/_____/_____ (mm dd yyyy) Dose 2_____/_____/_____ (mm dd yyyy) **Mumps** Dose 1_____/_____/_____ (mm dd yyyy) Dose 2_____/_____/_____ (mm dd yyyy) **Rubella** Dose 1_____/_____/_____ (mm dd yyyy) Dose 2_____/_____/_____ (mm dd yyyy)	2 doses of each individual component (2 measles, 2 mumps, 2 rubella) −At least 4 weeks between doses −First dose given after 1st birthday −Second dose after age 4
OR		OR
Positive blood test showing immunity	Measles titer date _____/_____/_____ (mm dd yyyy) Result_____ Mumps titer date _____/_____/_____ (mm dd yyyy) Result_____ Rubella titer date _____/_____/_____ (mm dd yyyy) Result_____	Positive titers ***Lab report must be attached**
AND		
Tdap	_____/_____/_____ (mm dd yyyy)	One dose within last 10 years

Last name:_____ UID:_____

SECTION B (REQUIRED): YOU MUST COMPLETE THIS SECTION IF YOU WILL BE LIVING IN ON-CAMPUS STUDENT HOUSING			
Meningitis (meningo-coccal vaccine)	_____/_____/_____ mm dd yyyy ☐ Check if waiver completed below in SECTION C	Check one ☐ Menactra ☐ Menveo ☐ Unknown	One dose given after age 16 Must be within the past 3 years May be waived by completing Section C

YOUR PROVIDER MUST SIGN HERE: Please review, sign, and stamp to verify that immunization dates and information are correct.

Clinician name (MD/NP/PA) | Clinician Signature | Clinician Phone Number | Date

SECTION C: MENINGOCOCCAL WAIVER (COMPLETE ONLY IF YOU HAVE NOT RECEIVED MENINGITIS VACCINE)

Maryland Law requires that all students living in **on-campus student housing** must either be vaccinated against meningococcal disease or complete a waiver.

FOR YOUR SAFETY, WE STRONGLY RECOMMEND RECEIVING THE VACCINE

Meningitis information can be found here:

http://phpa.dhmh.maryland.gov/OIDEOR/IMMUN/SitePages/meningococcal-disease.aspx

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

- ❑ I have reviewed information on the risk 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 that Maryland law requires that an individual enrolled in an institution of higher education in Maryland and who resides in campus student housing shall receive vaccination or sign this waiver.

I am 18 years of age or older and I choose to waive receipt of the meningococcal vaccine:

Signature Date

I choose to waive receipt of the meningococcal vaccine for my child who is under 18 years of age:

Signature Date

Continued on page 3

Last name:_____ UID:_____

SECTION D: REQUIRED TUBERCULOSIS RISK SCREENING

THIS MUST BE COMPLETED BY ALL STUDENTS ONLINE AT WWW.MYUHC.UMD.EDU

If you answered YES to any of questions on the Tuberculosis Risk Screening, you are required to provide the following:

Quantiferon Gold Test or T-Spot **TEST MUST BE PERFORMED IN THE US**	**Date of blood test** _____/_____/_____ mm dd yyyy	***You must attach laboratory report*** Result_____

If the result of the Quantiferon Gold or T-Spot is POSITIVE, your doctor should discuss treatment for latent TB.

Provide documentation of this review, even if you decline treatment, and your provider must complete the following:

Clinical evaluation:

- ❑ Normal (absence of cough, hemoptysis, fever, chills, sweats, weight loss).
- ❑ Abnormal (describe):_____

Chest X-ray	**Date of X-ray** _____/_____/_____ mm dd yyyy	**Attach X-ray report in English** Result_____

Treatment for latent TB (check one)

Attach additional clinical info if indicated.

- ❑ Patient completed full course of treatment for latent TB.

  Medication and dates_____
- ❑ Patient did not complete treatment for latent TB.

  Reason:

YOUR DOCTOR/PROVIDER MUST SIGN HERE: Please review, sign, and stamp to verify that the information above is correct.

Clinician name (MD/NP/PA)	Clinician Signature	Clinician Phone Number	Date

Continued on page 4

Last name:_____ UID:_____

SECTION E: *OPTIONAL*			
Vaccines	**Dates Given:**		
Varicella (chicken pox)	Dose 1_____/_____/_____ mm dd yyyy Dose 2_____/_____/_____ mm dd yyyy	OR	Date of Disease _____/_____/_____ mm dd yyyy
Hepatitis A	Dose 1_____/_____/_____ mm dd yyyy Dose 2_____/_____/_____ mm dd yyyy		
Hepatitis B or Twinrix	Dose 1_____/_____/_____ mm dd yyyy Dose 2_____/_____/_____ mm dd yyyy Dose 3_____/_____/_____ mm dd yyyy		
HPV	Check one ❑Gardisil ❑Cervarix Dose 1_____/_____/_____ mm dd yyyy Dose 2_____/_____/_____ mm dd yyyy Dose 3_____/_____/_____ mm dd yyyy		
Influenza yearly	_____/_____/_____ mm dd yyyy		

SECTION F: *OPTIONAL* -GENDER AND IDENTITY RELATED QUESTIONS

WE ASK THESE QUESTIONS TO PREPARE TO TAKE THE BEST, INCLUSIVE CARE OF YOU

These questions are located in the FORMS section of www.myuhc.umd.edu. Log in to complete them.

***Acceptable Documentation in Lieu of a Doctor/Provider Signature** includes a copy of an up-to-date high school or university immunization record, doctor/provider-signed personal immunization records, proof of current or previous active duty (DD214) status in the US Military or International W.H.O Yellow Book showing MMR dates (completed by a medical provider).

If you are in need of required vaccines, these are available at the University Health Center. Many insurances can be billed for the cost of the vaccines. Please call for an appointment when you arrive on campus.

*The University of Maryland requires that **ALL students** including credit/non-credit, degree/non-degree seeking, full-time/part-time, graduate/undergraduate, transfer and international students complete this form.

****Allow one week for processing after your form has been submitted.**

****Once your form has been processed, you will receive an email.**

****Student registration will be blocked if immunization information is missing.**

***Regarding the Mandatory Health Insurance Waiver**: Submission of this form does not meet the Mandatory Health Insurance Waiver Requirement! Evidence of insurance must be provided yearly online at www.firststudent.com.

End of form