University Health Center
University of Maryland
College Park, MD 20742
Mail to above address or Fax: 301-314-5234
(Cover sheet not required)
Immunization info: 301-314-8139

DIVISION OF STUDENT AFFAIRS
UNIVERSITY HEALTH CENTER

UID_____
Reviewer init_____
MMR_____
MEN_____
Cleared_____Prov_____

IMMUNIZATION RECORD

SECTION A (REQUIRED): 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?

Local US Address Cell Phone

Email Address

Parental Consent (for students under age 18) I give my 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 B (REQUIRED): REQUIRED IMMUNIZATION INFORMATION-ALL STUDENTS BORN AFTER 1956 MUST PROVIDE THIS INFORMATION

Vaccines	Dates Given/Performed	Requirement
MMR	Dose 1_____/_____/_____ (mm dd yyyy) Dose 2_____/_____/_____ (mm dd yyyy)	*2 doses of MMR *Minimum of 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) *Minimum of 4 weeks between doses *First dose given after 1st birthday *The second dose is recommended after age 4
OR		OR
Positive blood test showing immunity	**Attach laboratory report** Measles titer date _____/_____/_____ (mm dd yyyy) Result_____ Mumps titer date _____/_____/_____ (mm dd yyyy) Result_____ Rubella titer date _____/_____/_____ (mm dd yyyy) Result_____	*Positive titers

SECTION C (REQUIRED): IF YOU WILL BE LIVING IN ON-CAMPUS STUDENT HOUSING, YOU MUST PROVIDE THIS INFORMATION

Meningo-coccal (meningitis)	_____/_____/_____ (mm dd yyyy) Check one ☐ Menactra ☐ Menveo ☐ Check if waiver completed on page 3-Section F	*One dose given after age 16 within the past 3 years *May be waived by completing Section F

Your health care provider must sign page 3 of this form.

Last name_____ UNIVERSITY OF MARYLAND University ID#_____

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SECTION D (REQUIRED): ATTENTION! THIS MUST BE COMPLETED BY ALL STUDENTS, NOT BY YOUR DOCTOR.

Afghanistan	Congo	Kenya	Niger	Sri Lanka
Algeria	Côte d'Ivoire	Kiribati	Nigeria	Sudan
Angola	Dem Ppl's Rep of Korea	Kuwait	Niue	Suriname
Argentina	Dem Rep of Congo	Kyrgyzstan	Pakistan	Swaziland
Armenia	Djibouti	Lao Ppl's Democratic Rep	Palau	Taiwan
Azerbaijan	Dominican Republic	Latvia	Panama	Tajikistan
Bahrain	Ecuador	Lesotho	Papua New Guinea	Tanzania
Bangladesh	El Salvador	Liberia	Paraguay	Thailand
Belarus	Equatorial Guinea	Libya	Peru	Timor-Leste
Belize	Eritrea	Lithuania	Philippines	Togo
Benin	Estonia	Madagascar	Poland	Trinidad and Tobago
Bhutan	Ethiopia	Malawi	Portugal	Tunisia
Bolivia (Plurinational State of)	Fiji	Malaysia	Qatar	Turkey Turkmenistan
Bosnia and Herzegovina	Gabon	Maldives	Republic of Korea	Tuvalu
Botswana	Gambia	Mali	Republic of Moldova	Uganda
Brazil	Georgia	Marshall Islands	Romania	Ukraine
Brunei Darussalam	Ghana	Mauritania	Russian Federation	Unit'd Rep of Tanzania
Bulgaria	Guatemala	Mauritius	Rwanda	Uruguay
Burkina Faso	Guinea	Mexico	Saint Vincent/Grenadines	Uzbekistan
Burma	Guinea-Bissau	Micronesia	Sao Tome and Principe	Vanuatu
Burundi	Guyana	Mongolia	Senegal	Venezuela
Cabo Verde	Haiti	Morocco	Serbia	Viet Nam
Cambodia	Hong Kong	Mozambique	Seychelles	Yemen
Cameroon	Honduras	Myanmar	Sierra Leone	Zambia
Central African Republic	India	Namibia	Singapore	Zimbabwe
Chad	Indonesia	Nauru	Solomon Islands	
China	Iran (Islamic Republic of)	Nepal	Somalia	
Colombia	Iraq	Nicaragua	South Africa	***List is subject to change according to CDC Guidelines.***
Comoros	Kazakhstan		South Sudan	

1. Have you ever had close contact with persons with known or active TB (tuberculosis) disease?	❑ Yes	❑ No
2. Were you born or have you lived or travelled for more than one month in one of the countries listed below with a high incidence of active TB (tuberculosis) disease? (if yes, circle the country name above)	❑ Yes	❑ No
3. Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)?	❑ Yes	❑ No
4. Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease?	❑ Yes	❑ No
5. Have you ever been a member of any of the following groups that may have an increased incidence of latent *M. tuberculosis* infection or active TB disease – medically underserved, low-income, or abusing drugs or alcohol?	❑ Yes	❑ No

If you answered yes to any of these questions, the University of Maryland requires that you provide the following:

Interferon-based Assay TB Blood Test Quantiferon Gold Test or T-Spot *Must be performed in the United States.	**Date of blood test** _____/_____/_____ mm dd yyyy	**Attach laboratory report** Result_____

If the result of the above test is **POSITIVE**, you must provide the following:

Chest X-ray	**Date of X-ray** _____/_____/_____ mm dd yyyy	**Attach X-ray report in English** Result_____
Treatment for latent TB (check one)	❑ Patient completed full course of treatment for latent TB. Medication and dates_____ ❑ Patient did not complete treatment for latent TB. Reason_____	

Last name_____ University ID#_____

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SECTION E: **OPTIONAL** SECTION TO RECORD OTHER VACCINATIONS RECOMMENDED FOR YOUR GOOD HEALTH.

Vaccines	Dates Given/Performed				
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	Dose 1_____/_____/_____ mm dd yyyy	Dose 2_____/_____/_____ mm dd yyyy	Dose 3_____/_____/_____ mm dd yyyy	Check one ❑ Gardisil ❑Cervarix	
Tdap within 10 years	_____/_____/_____ mm dd yyyy	**Influenza yearly**	_____/_____/_____ mm dd yyyy		

To the clinician: Please review and sign to verify that that immunization dates noted are correct.

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

SECTION F: MENINGOCOCCAL WAIVER

Maryland Law requires that all students living in on-campus student housing must be vaccinated against meningococcal disease or complete a waiver. We strongly recommend that you receive the vaccine as opposed to waiving.
DO NOT COMPLETE THIS SECTION IF YOU HAVE RECEIVED THE MENINGOCOCCAL (MENINGITIS) VACCINE OR IF YOU WILL NOT RESIDE IN GRAD/UNDERGRAD CAMPUS HOUSING.

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 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

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PLEASE DO NOT SUBMIT THIS PAGE

IMPORTANT NOTICES

***Acceptable Documentation in Lieu of a Provider Signature for sections B, C, D, E** includes a copy of an up-to-date high school or university immunization record, 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.

***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, if necessary. 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.**

**Incomplete forms will NOT be processed and you will be notified by email.
**Student registration will be blocked if immunization information is not provided.
**To confirm immunization block removal: Allow one week for processing after your form has been sent then visit www.testudo.umd.edu and click on "registration", select your term and year in the drop down section, click "accept" then enter your directory ID number and your password. If you are still blocked the message will appear here.

***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.

PLEASE DO NOT SUBMIT THIS PAGE.