

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 one <input type="checkbox"/> Menactra <input type="checkbox"/> Menveo <input type="checkbox"/> Unknown	One dose given after age 16 Must be within the past 3 years May be waived by completing Section C
	<input type="checkbox"/> Check if waiver completed below in 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

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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 _____
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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 _____
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Treatment for latent TB (check one) Patient completed full course of treatment for latent TB.

Attach additional clinical info Medication and dates _____

if indicated. 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
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Continued on page 4

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 <input type="checkbox"/> Gardisil	Dose 1 ____/____/____ mm dd yyyy	Dose 2 ____/____/____ mm dd yyyy	Dose 3 ____/____/____ mm dd yyyy
	<input type="checkbox"/> Cervarix			
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