University Health Center
University of Maryland
College Park, MD 20742
Upload form to myuhc.umd.edu
Or mail to above address or Fax: 301-314-5234
(Cover sheet not required)
Immunization info: 301-314-8114

DIVISION OF STUDENT AFFAIRS
UNIVERSITY HEALTH CENTER

Form is due at Orientation

IMMUNIZATION RECORD

Form is due at Orientation! You may be assessed a late fee for submitting this form after the first day of class.

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): 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 *Second dose 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
AND		
Tdap	_____/_____/_____ (mm dd yyyy)	*One dose within 10 years

SECTION B (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	*One dose given after age 16 within the past 3 years *May be waived by completing Section C

☐ Check if waiver completed on page 2-Section C

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 be vaccinated against meningococcal disease or complete a waiver.

WE STRONGLY RECOMMEND RECEIVING THE VACCINE AS OPPOSED TO WAIVING FOR YOUR SAFETY.

DO NOT COMPLETE THIS SECTION IF YOU HAVE RECEIVED THE MENINGOCOCCAL (MENINGITIS) VACCINE OR IF YOU WILL NOT RESIDE IN UNDERGRADUATE 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 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

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

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 on the next page with a high incidence of active TB (tuberculosis) disease? (if yes, circle the name on the next page)	❑ 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

Continued on page 3

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

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

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

Interferon-based Assay TB Blood Test **Quantiferon Gold Test or T-Spot** ***Lab report must be attached.**	**Date of blood test** _____/_____/_____ mm dd yyyy	**Attach laboratory report** Result_____

If the result of the IGRA (Quantiferon Gold or T-Spot) is POSITIVE, your doctor/provider must provide 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 and sign to verify that that immunization dates and information noted are correct.

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

SECTION E: *OPTIONAL*		
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	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

What is your current gender identity? (check all the apply)

- ❑ Male
- ❑ Female
- ❑ Female-to-Male (FTM)/Transgender Male/Trans Man
- ❑ Male-to-Female (MTF)/Transgender Female/Trans Woman
- ❑ Genderqueer, neither exclusively male nor female
- ❑ Additional Gender Category:_____

What sex were you assigned at birth on your birth certificate?

- ❑ Male
- ❑ Female
- ❑ Decline to answer

***Acceptable Documentation in Lieu of a Doctor/Provider Signature for sections B, C, D, E** 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.**

**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.

Instructions for Students to Submit Immunization Records Online

Step 1: Complete the University Health Center's Immunization Record (see above)

Step 2: Go to www.myuhc.umd.edu

Step 3: Enter your Directory ID and password to log on

Step 4: Enter your UID (University ID) in the box and hit enter

Step 5: Click on Forms (located on the left hand side of the page)

Step 6: Click on Immunizations (in the middle of the page)

Step 7: Carefully enter your immunization dates in the appropriate areas of the form

Step 8: Scroll down to the gray box and click "Add immunization record…"

(Please make sure you attach the health center's Immunization Record as well as any additional documentation from your physician)

Step 9: When finished, click Submit Final (blue box) to complete the process

The University Health Center will receive the immunization record. It will be reviewed within approximately 3-5 business days. Once reviewed, a secure message will be sent to you (you must log in to www.myuhc.umd.edu to retrieve the message) either confirming that you have been cleared or advising what to do if some immunization information is missing.