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.

<table>
<thead>
<tr>
<th>Name (Last)</th>
<th>First</th>
</tr>
</thead>
<tbody>
<tr>
<td>University ID#</td>
<td>Date of Birth (mm/dd/yyyy)</td>
</tr>
</tbody>
</table>

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 ___/___/___  Dose 2 ___/___/___ | *2 doses of MMR  
  *Minimum of 4 weeks between doses  
  *First dose given after 1st birthday  
  *Second dose after age 4 |
| Measles | Dose 1 ___/___/___  Dose 2 ___/___/___ | *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 |
| Mumps | Dose 1 ___/___/___  Dose 2 ___/___/___ |
| Rubella | Dose 1 ___/___/___  Dose 2 ___/___/___ |

Attach laboratory report

Measles titer date  ___/___/___  Result  
Mumps titer date  ___/___/___  Result  
Rubella titer date  ___/___/___  Result  

Tdap  ___/___/___  *One dose within 10 years

| SECTION B (REQUIRED): IF YOU WILL BE LIVING IN ON-CAMPUS STUDENT HOUSING, YOU MUST PROVIDE THIS INFORMATION |
|---|---|
| Meningocoecal (meningitis) | Check one |
| | Menactra  
  *One dose given after age 16 within the past 3 years  
  *May be waived by completing Section C |
| | Mencevo  
  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:

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.

<table>
<thead>
<tr>
<th>Country</th>
<th>Country</th>
<th>Country</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan</td>
<td>Côte d’Ivoire</td>
<td>Kenya</td>
<td>Nicaragua</td>
</tr>
<tr>
<td>Algeria</td>
<td>Dem Ppl's Rep of Korea</td>
<td>Kiribati</td>
<td>Niger</td>
</tr>
<tr>
<td>Angola</td>
<td>Dem Rep of Congo</td>
<td>Kuwait</td>
<td>Nigeria</td>
</tr>
<tr>
<td>Argentinia</td>
<td>Djibouti</td>
<td>Kyrgyzstan</td>
<td>Niue</td>
</tr>
<tr>
<td>Armenia</td>
<td>Dominican Republic</td>
<td>Lao Ppl's Democratic Rep</td>
<td>Northern Marian Islands</td>
</tr>
<tr>
<td>Azerbaijan</td>
<td>Ecuador</td>
<td>Latvia</td>
<td>Pakistan</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>El Salvador</td>
<td>Lesotho</td>
<td>Palau</td>
</tr>
<tr>
<td>Belarus</td>
<td>Equatorial Guinea</td>
<td>Liberia</td>
<td>Panama</td>
</tr>
<tr>
<td>Belize</td>
<td>Eritrea</td>
<td>Libya</td>
<td>Papua New Guinea</td>
</tr>
<tr>
<td>Benin</td>
<td>Estonia</td>
<td>Lithuania</td>
<td>Paraguay</td>
</tr>
<tr>
<td>Bhutan</td>
<td>Ethiopia</td>
<td>Madagascar</td>
<td>Peru</td>
</tr>
<tr>
<td>Bolivia (Plurinational State of)</td>
<td>Fiji</td>
<td>Malawi</td>
<td>Philippines</td>
</tr>
<tr>
<td>Bosnia and Herzegovina</td>
<td>Gabon</td>
<td>Malaysia</td>
<td>Portugal</td>
</tr>
<tr>
<td>Botswana</td>
<td>Gambia</td>
<td>Maldives</td>
<td>Qatar</td>
</tr>
<tr>
<td>Brazil</td>
<td>Georgia</td>
<td>Mali</td>
<td>Republic of Korea</td>
</tr>
<tr>
<td>Brunei Darussalam</td>
<td>Ghana</td>
<td>Marshall Islands</td>
<td>Republic of Moldova</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>Greenland</td>
<td>Mauritania</td>
<td>Romania</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>Guam</td>
<td>Mauritius</td>
<td>Russian Federation</td>
</tr>
<tr>
<td>Burma</td>
<td>Guatemala</td>
<td>Mexico</td>
<td>Rwanda</td>
</tr>
<tr>
<td>Burundi</td>
<td>Guinea</td>
<td>Micronesia</td>
<td>Sao Tome and Principe</td>
</tr>
<tr>
<td>Cabo Verde</td>
<td>Guinea-Bissau</td>
<td>Mongolia</td>
<td>Senegal</td>
</tr>
<tr>
<td>Cambodia</td>
<td>Guyana</td>
<td>Morocco</td>
<td>Serbia</td>
</tr>
<tr>
<td>Cameroon</td>
<td>Haiti</td>
<td>Mozambique</td>
<td>Seychelles</td>
</tr>
<tr>
<td>Central African Republic</td>
<td>Hong Kong</td>
<td>Myanmar</td>
<td>Sierra Leone</td>
</tr>
<tr>
<td>Chad</td>
<td>Honduras</td>
<td>Namibia</td>
<td>Singapore</td>
</tr>
<tr>
<td>China</td>
<td>India</td>
<td>Nauru</td>
<td>Solomon Islands</td>
</tr>
<tr>
<td>Colombia</td>
<td>Indonesia</td>
<td>Nepal</td>
<td>Somalia</td>
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<tr>
<td>Comoros</td>
<td>Iraq</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Congo</td>
<td>Kazakhstan</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**
  - Date of blood test
  - Attach laboratory report
    - Result
      - mm
      - dd
      - yyyy

- **Quantiferon Gold Test or T-Spot**
  - *Lab report must be attached.*

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
  - Attach X-ray report in English
    - Result
      - mm
      - dd
      - yyyy

- **Treatment for latent TB (check one)**
  - Patient completed full course of treatment for latent TB.
  - 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.*
**SECTION E: OPTIONAL**

### Vaccines

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Dose 1</th>
<th>Dose 2</th>
<th>Date of Disease</th>
<th>OR</th>
<th>Dose 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Varicella (chicken pox)</td>
<td>mm dd yyyy</td>
<td>mm dd yyyy</td>
<td>mm dd yyyy</td>
<td>OR</td>
<td>mm dd yyyy</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>mm dd yyyy</td>
<td>mm dd yyyy</td>
<td>mm dd yyyy</td>
<td>OR</td>
<td>mm dd yyyy</td>
</tr>
<tr>
<td>Hepatitis B or Twinrix</td>
<td>mm dd yyyy</td>
<td>mm dd yyyy</td>
<td>mm dd yyyy</td>
<td>OR</td>
<td>mm dd yyyy</td>
</tr>
<tr>
<td>HPV</td>
<td>mm dd yyyy</td>
<td>mm dd yyyy</td>
<td>mm dd yyyy</td>
<td>OR</td>
<td>mm dd yyyy</td>
</tr>
<tr>
<td>Influenza yearly</td>
<td>mm dd yyyy</td>
<td>mm dd yyyy</td>
<td>mm dd yyyy</td>
<td>OR</td>
<td>mm dd yyyy</td>
</tr>
</tbody>
</table>

**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
- Declare 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.