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 ONLINE no later than the first day of class

Instructions for uploading immunizations:

Step 1: Go to www.myuhc.umd.edu
Step 2: Enter your **directory ID** and **password** to log on, then enter your **UID** (University ID) in the box and hit ENTER
Step 3: Click on **Forms** (located on the left hand side of the page), then click on **Immunizations** (in the middle of the page)
Step 4: Carefully enter your immunization dates in the appropriate fields
Step 5 : Scroll down to the gray box and click "Add Immunization Record" to attach your **supporting documentation.**
You can scan or take a photo of the documents which can then be uploaded.
You may save your entries and return to them later, but once you click Submit Final, you will not be able to make changes

Submit this form with your provider's signature as **supporting documentation**.
If your provider does not sign this form, you must attach ONE of the following alternative forms of **supporting documentation:**

1. Vaccine record from your doctor/provider office that includes provider information
2. Up to date school or university immunization record
3. Provider signed proof of current or previous immunizations
4. Active duty (DD214) status in the US Military or International W.H.O Yellow Book showing MMR dates (completed by a medical provider)

We ask that supporting documentation please be in English

If you are in need of required vaccines, these are available at the University Health Center.
Please call for an appointment when you arrive on campus. Many insurances can be billed for the cost of the vaccines.
*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 a secure message by 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 https://umd.myahpcare.com/waiver.

PLEASE PRINT LEGIBLY IN BLUE OR BLACK INK.

Name (Last)	First
University ID#	Date of Birth (mm/dd/yyyy)
Cell phone number:	Email Address:
What is your home country?	

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

Last name_____ UNIVERSITY OF MARYLAND University ID#_____

IMMUNIZATION RECORD

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 given at age 11 or later
SECTION B (REQUIRED): ALL UNDERGRADUATE STUDENTS MUST COMPLETE THIS SECTION		
Meningitis (ACWY) meningo-coccal vaccine	_____/_____/_____ (mm dd yyyy) Check one: ☐ Menactra ☐ Menveo ☐ Unknown ☐ Check if waiver completed below in SECTION C	One dose given after age 16 −May be waived by completing Section C
YOUR DOCTOR/PROVIDER MUST SIGN HERE: Please review, sign, and stamp to verify 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)

All **undergraduate** students 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:
https://phpa.health.maryland.gov/OIDEOR/IMMUN/Pages/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 TUBERCULOSIS RISK SCREENING

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

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

	Date of blood test	***You must attach laboratory report***
Quantiferon Gold Test or T-Spot ***Test MUST BE PERFORMED IN THE US*** **(PPD will not be accepted)**	_____/_____/_____ mm dd yyyy	Test must have been performed within the past 12 months 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):_____

	Date of X-ray (must be within 1 year)	**Attach X-ray report in English**
Chest X-ray	_____/_____/_____ mm dd yyyy	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

SECTION E: *RECOMMENDED VACCINES*	
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
Meningitis B (check one)	☐ Bexsero Dose 1_____/_____/_____ mm dd yyyy Dose 2_____/_____/_____ mm dd yyyy
	☐ Trumenba Dose 1_____/_____/_____ mm dd yyyy Dose 2_____/_____/_____ mm dd yyyy Dose 3_____/_____/_____ mm dd yyyy
Influenza (yearly)	_____/_____/_____ mm dd yyyy

SECTION F: *RECOMMENDED*

GENDER AND IDENTITY RELATED QUESTIONS

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

THESE QUESTIONS CAN BE COMPLETED ONLINE AT WWW.MYUHC.UMD.EDU

Thank you for completing the IMMUNIZATION RECORD!