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

UNIVERSITY HEALTH CENTER

For Health Center Use Only

UID# _____
Initials _____
MMR ❑ MEN ❑
Cleared _____ Prov _____

Immunization Record

Form is due at Orientation

Forms received after the first day of classes will be assessed a non-compliance fee.

SECTION A (REQUIRED): TO BE COMPLETED BY ALL STUDENTS. Print legibly in blue or black ink.

Name (Last) _____ (First) _____ (Middle) _____

University ID# _____ Date of Birth _____

Student Status: U.S. Citizen ❑ Permanent Resident ❑ International ❑ Country of Origin: _____

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 son/daughter until they turn 18. The Health Center will try to notify parents in the event of an emergency.

Signed _____ Relationship _____

SECTION B (REQUIRED): TO BE COMPLETED FOR ALL STUDENTS born after 1956.

All doses of measles, mumps, rubella (MMR) vaccines must be given after the 1st (first) birthday. History of disease not accepted.

Td ■ **OR** Tdap ■ (Within 10 years)
Vaccination Date:

AND

MEASLES (Rubeola):	Date of Dose 1:
	Date of Dose 2:
MUMPS:	Vaccination Date:
RUBELLA:	Vaccination Date:

OR

MMR:	Date of Dose 1:
	Date of Dose 2:

SECTION C (Recommended immunizations for good health): Record other immunizations received.

	Chicken Pox/Varivax	Hepatitis A	Hepatitis B	HPV	Menactra ❑ **OR** Menveo ❑
DATE(S)	#1	#1	#1	#1	
	#2	#2	#2	#2	**Meningitis waiver available in Section G.**
			#3	#3	

SECTION D (REQUIRED): TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE

All incoming students are required to complete this questionnaire.

Have you ever had a positive TB Skin Test?	Have you ever been exposed to anyone with active TB?	Have you ever had TB?	Have you received the BCG* vaccine?	Have you ever taken INH/ Rifampin** medication?
Yes ❑ No ❑	Yes ❑ No ❑	Yes ❑ No ❑	Yes ❑ No ❑	Yes ❑ No ❑
In the past year have you had any of the following symptoms?				
Persistent Cough Yes ❑ No ❑	Persistent Fever Yes ❑ No ❑	Loss of Appetite Yes ❑ No ❑	Night Sweats Yes ❑ No ❑	Chest Pains Yes ❑ No ❑
Coughing Up Blood Yes ❑ No ❑	Shortness of Breath Yes ❑ No ❑	Unexplained Weight Yes ❑ No ❑	Weakness or Fatigue Yes ❑ No ❑	

* BCG -not given in US
** INH/Rifampin -a medication for TB/Latent TB

FORM CONTINUES ON NEXT PAGE

Name (Last)_____ University ID#_____

SECTION E: INTERNATIONAL STUDENTS

If you are not from one of the countries listed below, you are required to complete this section.

Albania, Andorra, Antigua and Barbuda, Australia, Austria, Bahamas, Barbados, Belgium, Bermuda, British Virgin Islands, Canada, Chile, Cook Islands, Costa Rica, Cayman Islands, Cuba, Cyprus, Czech Republic, Denmark, Dominica, Egypt, Finland, France, French Polynesia, Germany, Greece, Grenada, Hungary, Iceland, Iran (Islamic Republic of), Ireland, Israel, Italy, Jamaica, Jordan, Lebanon, Luxembourg, Malta, Mexico, Monaco, Nauru, Netherlands, New Zealand, Norway, Oman, Puerto Rico, Saint Kitts and Nevis, San Marino, Saint Lucia, Samoa, Saudi Arabia, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tonga, Trinidad and Tobago, United Arab Emirates, United Kingdom, United States of America, West Bank and Gaza Strip. *(Source: As identified by the World Health Organization (WHO) Global Health Observatory and the American College Health Association.)*

Tests must have been performed in the US within the last 6 months.				
TB Skin Test by PPD (Mantoux)	Date Placed	Date Read	MM	Neg Pos
OR				**Chest X-ray is required if:**
Interferon-based Assay (QFT or Tspot) (Submit Copy of Lab Report)	Date	Result	Result	**• PPD Skin Test is positive (or history of positive)**
Chest X-Ray (if positive PPD, QFT, or TSPOT) (Submit Copy of Chest X-Ray Report in English.)	Date	Result	Result	**• QFT Gold Test is positive or • TSPOT Test is positive**

SECTION F (REQUIRED): PHYSICIAN SIGNATURE OR ACCEPTABLE DOCUMENTATION

Physicians: Complete sections B through F.

PHYSICIAN SIGNATURE_____ DATE_____

PHYSICIAN NAME (printed)_____ PHONE #_____

Acceptable Documentation in Lieu of Physician Signature

Copies of acceptable documentation should be attached to this form with Section A completed.

- A copy of your high school immunization record (in English)
- Personal immunization records (in English) with your physician's signature.
- Proof of current or previous active duty (DD214) status in the U.S. Military will be accepted.
- Copy of Lab Titer Report for Measles, Mumps, and Rubella
- International Certificate of Vaccination (in English), reflecting the information required in **Section B.**
- Immunization Exemptions: **Letter Required**. Attach to form. Religious ❑ Medical ❑

SECTION G: MENINGOCOCCAL WAIVER

DO NOT complete this section if you have received the vaccine or will not reside in campus housing.

I understand that Maryland law requires enrolled students in a Maryland institution of higher education and who reside in on-campus student housing be vaccinated against meningococcal disease. I may seek exemption from this law. I have read the meningitis bulletin available from the University of Maryland Health Center and at http://www.health.umd.edu/newandtransfer/immunizations/meningitis where the risks are detailed. In addition, I acknowledge the detrimental health effects of the disease. Lastly, I have read and understand the effectiveness of the vaccine, which is available from the University Health Center.

❑ I do not wish to receive the vaccine and I voluntarily agree to release, discharge, indemnify and hold harmless the State of Maryland, the University, its officers, employees and agents from any and all costs, liabilities, expenses, claims, demands, or causes of action on account of any loss or personal injury that might result from my non-compliance with the law.

To be completed by student and parent/guardian, if applicable.
I have read and signed this document with full knowledge of its significance. I further state that I am at least 18 years of age and competent to sign this waiver.

Student Signature_____ Date_____ UID#_____

Students under age 18: A parent/guardian must also sign this waiver.

Signature of Parent/Guardian_____ Date _____

Name of Parent/Guardian (Printed)_____

HLTH-601 (Revised 3.12)

Make a copy of these documents for your personal files.

Revised 3.12

DO NOT SUBMIT THIS PAGE

NOTICES

- This Immunization Record form DOES NOT meet the **Mandatory Health Insurance Requirement**.
- All undergraduate students must have health insurance. For more information, go to www.health.umd.edu.
- Students must bring their health insurance card when being seen at the University Health Center.

Registration/Immunization Blocks

The University of Maryland requires **ALL** students including: credit/non-credit, degree/non-degree seeking, full/part/half-time, undergraduate, graduate, transfer, International, or other student status to complete this Immunization Record form.

- Incomplete forms will **NOT** be processed and we will try to notify you by email.
- Students are permitted to register at the University of Maryland, College Park prior to submitting this form for the first class registration only.
- Failure to submit a completed Immunization Record will result in a Registration Block for the future semester and a non-compliance fee will be assessed. The Registration Block will be removed after the Immunization Record has been submitted and processed.
- To confirm immunization block removal: Wait one week after form has been submitted, then check: www.testudo.umd.edu
  (**Click** on *Office of the Registrar*, **Click** *Appointment and Registration Status* (under limited access), then **Log In**, **Select** *Academics and Testudo,* **View** *Registration and Time Blocks* box on left.)

Did you know?

- The Health Center **Pharmacy** participates with many pharmacy insurance plans, offers over-the-counter medications at discount prices, in addition to an array of Burt's Bees skin care products.
- Our **International Travel Clinic** offers immunization and guidance for international travel and studying abroad. Before you depart, make your first stop at the Health Center.
- The Health Center is in-network with the PPO and EPO insurance products of **Aetna**, **United Healthcare**, and **Carefirst/Blue Cross Blue Shield**, and **Cigna**.*
- Our **Women's Health Clinic** offers compassionate care for women including annual exams, colposcopy, contraceptive services and other testing.
- All **vaccines** are available at the Health Center at the most affordable prices.

For more information about all the services at the Health Center:

www.health.umd.edu

UNIVERSITY HEALTH CENTER

Leading the Way to Healthier Terps

* effective 6/2012

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Make a copy of your documents for your personal files.