UNIVERSITY HEALTH CENTER

IMMUNIZATION RECORD

NAME (LAST): _____ (FIRST): _____ UID: _____

D.O.B: _____ COUNTRY OF ORIGIN: _____ EMAIL: _____

☐ SNAPS

☐ SHAC

☐ CARE ADVOCATE

☐ INTERN - DEPT: _____

☐ VOLUNTEER - DEPT: _____

Copies of immunizations and labs must be attached to this form

	DATE	DATE	DATE	TITER DATE	TITER DATE
MMR					
Measles					
Mumps					
Rubella					
Varicella					
Hepatitis B					
Tdap					
Influenza					
	DATE GIVEN	DATE READ	RESULTS		
PPD #1					
PPD #2					
Quantiferon					

FOR HEALTH CENTER USE ONLY

Initials: _____ Cleared: _____ Not Cleared: _____

MAIL: University Health Center, Building 140 Campus Drive, College Park, MD 20742

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