

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 **Enter my COVID-19 Vaccine Information** and follow instructions

Step 4: Click on **Forms** (located on the left hand side of the page), then click on **Immunizations** (in the middle of the page)

Step 5: Carefully enter your immunization dates in the appropriate fields

Step 6: 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 must click Submit Final for your information to be transmitted. Please note, you will not be able to make changes after this step

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

SECTION A: REQUIRED FOR ALL STUDENTS

| | |
|-----------------|--|
| COVID-19 | Visit myuhc.umd.edu and click on Enter my COVID-19 Vaccine Information: |
| | <input type="checkbox"/> I have uploaded my COVID-19 vaccination information to the myuhc.umd.edu portal |

SECTION B (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 | |
| Individual Vaccines: -Measles -Mumps -Rubella | Measles | 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 |
| | Dose 1 ____/____/____ Dose 2 ____/____/____ mm dd yyyy mm dd yyyy | |
| | Mumps | |
| | Dose 1 ____/____/____ Dose 2 ____/____/____ mm dd yyyy mm dd yyyy | |
| Positive blood test showing immunity | Rubella | Positive titers *Lab report must be attached |
| | Dose 1 ____/____/____ Dose 2 ____/____/____ mm dd yyyy mm dd yyyy | |
| OR | OR | OR |
| Tdap | Measles titer date ____/____/____ Result _____ mm dd yyyy | |
| | Mumps titer date ____/____/____ Result _____ mm dd yyyy | |
| AND | Rubella titer date ____/____/____ Result _____ mm dd yyyy | |
| | ____/____/____ mm dd yyyy | |
| | | One dose given at age 11 or later |

SECTION C (REQUIRED): ALL UNDERGRADUATE STUDENTS MUST COMPLETE THIS SECTION

| | | | |
|--|---|---|---|
| Meningitis (ACWY) meningococcal vaccine | <p align="center"> ____/____/____ mm dd yyyy </p> <p><input type="checkbox"/> Check if waiver completed below in SECTION D</p> | Check one <input type="checkbox"/> Menactra <input type="checkbox"/> Menveo <input type="checkbox"/> Unknown | 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 D: 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 E: 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:

| | | |
|--|--|--|
| Quantiferon Gold Test or T-Spot *Test MUST BE DONE IN THE US* (PPD will not be accepted) | Date of blood test ____/____/____ mm dd yyyy | *You must attach laboratory report* 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) ___ Patient completed full course of treatment for latent TB.
 *Attach additional clinical info Medication and dates _____
 if indicated. ___ 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 F: RECOMMENDED VACCINES

In addition to the required vaccines, we recommend that you attach your complete immunization record from your medical provider. Please visit the Advisory Committee on Immunization Practices (ACIP) website (cdc.gov/vaccines/schedules/hcp/index.html) for immunization schedules by age group.

**SECTION G: 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!