This Form is to be Completed and Signed by a Health Care Provider

Proof of immunity is required prior to registration. Any contraindications to immunizations must be documented.

Status:  □ Undergraduate  □ Graduate  □ Full-time  □ Part-time

A. M.M.R. (Measles, Mumps, Rubella) (Two doses required)
   1. Dose No. 1 given at age 12-15 months or later  No. 1 ________/_______  Month  Year
   2. Dose No. 2 given at age 4-6 years or later, and at least one month after first dose  No. 2 ________/_______  Month  Year

B. TETANUS-DIPHTHERIA
   Tetanus-Diphtheria (Td) booster within the last 10 years  ________/_______  Month  Year

C. POLIO: Check One
   Primary series of immunization completed with:
   □ oral vaccine □ inactivated □ E-IPV  Last booster date ________/_______/_______  Month  Day  Year

D. MENINGOCOCCAL TETRAVALENT (A, C, Y, W-135) (Maryland requires all residential students receive the meningococcal vaccine or sign a waiver below to the vaccination.)
   Tetravalent conjugate (preferred; data for revaccination pending):  Date ________/_______  Month  Year
   Tetravalent polysaccharide (acceptable alternative if conjugate is not available; revaccinate every 3-5 years if increased risk continues):  Date ________/_______  ________/_______  Month  Year  Month  Year
   WAIVER:
   I decline the meningococcal vaccine at this time. ___________________________________________  Date ________/_______  Month  Year

E. TUBERCULOSIS SCREENING
   1. Does the student have signs or symptoms of active tuberculosis disease?  □ Yes  □ No
      (If No, proceed to No. 2. If Yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.)
   2. Is the student a member of a high-risk* group or is the student entering the health professions?  □ Yes  □ No
   3. Tuberculin Skin Test:
      Date Given: ________/_______/_______  Date Read: ________/_______/_______  Month  Day  Year
      Result: ________ (Record actual mm of induration, transverse diameter; if no duration, write “0”)  Interpretation (based on mm of induration as well as risk factors): Positive ________ Negative ________
   4. Chest X-ray (required if tuberculin skin test is positive)  Result: Normal ________ Abnormal ________
      Date of Chest X-ray ________/_______/_______  Month  Day  Year

*Categories of high-risk students include those students who have arrived within the past five years from countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Therefore, students should undergo TB screening if they have arrived from countries EXCEPT those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia, U.S.A., U.S. Virgin Islands, Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Austria or New Zealand.
RECOMMENDED BUT NOT REQUIRED IMMUNIZATIONS

A. VARICELLA
1. History of Disease  ☐ Yes  ☐ No
2. Immunization:
   a. Dose No. 1  No. 1 _____/______
      Month Year
   b. Dose No. 2, given at least one month after first dose, if age 13 years or older  No. 2 _____/______
      Month Year

B. HEPATITIS B
1. Immunization
   a. Dose No. 1 _____/______  b. Dose No. 2 _____/______  c. Dose No. 3 _____/______
      Month Year Month Year Month Year

HEALTH CARE PROVIDER INFORMATION
Name ________________________________________________________________
Address _____________________________________________________________
Signature ______________________________________ Phone ___________________