Immunization Record

Office of Accessibility & Health Promotion
Notre Dame of Maryland University , 4701 N. Charles St., Baltimore, Maryland 21210
amorales@ndm.edu; (410) 532-5401

For University Use Only
UID# _____
Staff Initials _____
MMR ❑ MEN ❑
Date received _____

ALL students must complete and signed. If student is under 18 yrs of age, Section A must be signed by parent/legal guardian. ALL students born after 12/31/1956 must provide proof of immunizations listed in Section B. Section B must be completed and signed by a healthcare provider OR an official immunization record must be attached.
This form, along with any applicable outside records, must be submitted prior to the start of the academic year. Undergraduate students should submit forms via mail, fax (410-532-5764), or in person to the Office of Accessibility & Health Promotion. For English Language Institute (ELI) and international students, please send to a fax to 410-532-5794. School of Pharmacy students may send to SOP Admissions fax to 410-532-5355. All records must be in English and completed in entirety.

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 ____/____/____ College: Women's ____ CAUS _____ Graduate ___

Student Status: Resident ❑ Commuter ❑ ELI/International (If so, Country of Origin) _____
School: Arts, Sciences, & Business_____ Education_____ Nursing_____ Pharmacy _____

Permanent Address _____

Cell Phone _____ Email Address _____

Parental/Legal Guardian Consent (for students under age 18) I give my permission for such diagnostic and therapeutic procedures as may be deemed necessary for my student until they turn 18. The University will try to notify listed emergency contact.
Signed _____ Relationship _____

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

All doses of measles, mumps, rubella (MMR) vaccines must be given after the 1st (first) birthday and after1967. History of disease not accepted.

MMR	Dose 1	Dose 2
	____/____/____ M D YYYY	____/____/____ M D YYYY

Serological confirmation of immunity accepted. Attach copy of lab results. (Must be in English.)

OR

	Dose 1	Dose 2
MEASLES (Rubeola):	____/____/____ M D YYYY	____/____/____ M D YYYY
MUMPS:	____/____/____ M D YYYY	____/____/____ M D YYYY
RUBELLA:	____/____/____ M D YYYY	____/____/____ M D YYYY

SECTION C (REQUIRED): TO BE COMPLETED FOR ALL STUDENTS. TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE

All incoming students are required to complete this questionnaire.

Have you ever had a POSITIVE test for TB?	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 for a period of time greater than six months?

Persistent Cough	Persistent Fever	Loss of Appetite	Night Sweats	Chest Pains
Yes ❑ No ❑	Yes ❑ No ❑	Yes ❑ No ❑	Yes ❑ No ❑	Yes ❑ No ❑

Coughing Up Blood	Shortness of Breath	Unexplained Weight Loss	Weakness or Fatigue	If "YES", explain:
Yes ❑ No ❑	Yes ❑ No ❑	Yes ❑ No ❑	Yes ❑ No ❑	

* BCG -not given in US
** INH (Isoniazid) or Rifampin -a medication for TB/Latent TB

SECTION D (Required immunizations for good health): Record other immunizations received.

	Chicken Pox/Varivax	Hepatitis A	Hepatitis B	HPV	Meningococcal Vaccine Menactra❑ OR Menveo❑ 2nd dose given after age 16 or within past 3 years	Td ❑ OR Tdap ❑ (Within 10 years)
Dose 1	____/____/____ M D YYYY	____/____/____ M D YYYY	____/____/____ M D YYYY	____/____/____ M D YYYY		
Dose 2	____/____/____ M D YYYY	____/____/____ M D YYYY	____/____/____ M D YYYY	____/____/____ M D YYYY	____/____/____ M D YYYY	____/____/____ M D YYYY
	History of disease accepted. Date:_____		____/____/____ M D YYYY	____/____/____ M D YYYY	____/____/____ M D YYYY	

Reminder: Complete Section C.
FORM CONTINUES ON NEXT PAGE

OR Hepatitis B waiver

OR Meningitis waiver: Section G

Name (Last) _____ University ID# _____

SECTION E: INTERNATIONAL STUDENTS ONLY

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, Ireland, Israel, Italy, Jamaica, Jordan, Lebanon, Luxembourg, Malta, Mexico, Monaco, 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.)

Interferon-based Assay must have been performed within the last year.		
Interferon-based Assay TB Blood Test) (Quantiferon Gold Test or T-Spot)	Date	Result: Attach copy of Lab Report
Chest X-Ray Required if Quantiferon Gold Test or T-Spot is POSITIVE		
Chest X-Ray (Needed ***ONLY*** if TB Blood Test is POSITIVE)	Date	Result: Attach copy of Radiology Report (in English)

SECTION F (REQUIRED): PHYSICIAN SIGNATURE with ACCEPTABLE DOCUMENTATION

PHYSICIAN SIGNATURE _____ DATE _____

PHYSICIAN NAME (printed) _____ PHONE # _____

Acceptable Documentation with Physician's Signature

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

- A copy of your high school immunization record (in English)
- Personal immunization records (written in English) with your physician's signature. Digital copies are not accepted.
- 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 at http://www.ndm.edu/healthservices 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's health services partner.

❑ 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.

FORM CONTINUES ON NEXT PAGE

Name (Last):_____ University ID #:_____

SECTION H: EMERGENCY CONTACT, INSURANCE, & HEALTH HISTORY (REQUIRED FOR ALL STUDENTS)

Emergency Contact:

_____ _____
Full Name (Please print or type) Relationship

_____ _____ _____
Home Phone Number Work Phone Email Address

Primary Physician/ Health Insurance Provider:

_____
Physician/Provider Name Telephone Fax

_____
Address City State Zip

_____
Health Insurance Provider/Company Name Policy Number Group Number

_____
Provider Address City State Zip

Please note that all full-time NDMU students are mandated to complete the online waiver/enrollment process for the university-sponsored plan in addition to providing this information above to avoid any unneccessary charges to University tuition accounts. More information is available at www.ndm.edu/healthservices.com.

Medical History:

Allergies (Please list any allergies to drugs, food, insect, stings, etc. - specify drug allergies)

_____
_____
_____
_____

Please tell us about any chronic health conditions, disabilities, serious illnesses or medications which may impact your health while at Notre Dame of Maryland University. Attach pertinent records. _____

_____
_____
_____
_____

Please note that it is the student's responsibility to contact the University's Office of Accessibility & Health Promotionshould accommodations be needed either in the classroom, the residence halls, or other campus locations. For more information, accommodations, or scheduling appointments, please contact Amy Morales, Director of Accessibility & Health Promotions, at amorales@ndm.edu.

Parental Consent to Medical And/Or Surgical Treatment of Minor:

To be completed by the parents or guardians of students who will be younger than 18 upon arrival on campus.

The laws of Maryland require that surgical and medical treatment of minors and release of medical information to hospitals, other physicians, and insurance companies about conditions treated by us be at the request of and with the approval of their parents/guardians. This right to request an approval may be delegated to University officials. Although it is our policy to notify the parents or guardians as soon as possible in the event of major illness or injury, it is impractical to notify for every minor illness or injury requiring treatment. It will help us protect the health of your student if you will delegate to use discretion in these matters.

I give my permission for such diagnostic and therapeutic procedures as may be deemed necessary for my student while attending Notre Dame of Maryland University and agree to present information concerning any medical condition to other responsible University officials when deemed desirable. No major operations will be performed, except in extreme emergency without parents/guardians being fully informed.

_____
Signature of Parent or Legal Guardian Date

_____
Signature of Student Date