Immunization Record

Division of Student Life
Notre Dame of Maryland University Baltimore, Maryland 21210
studentlife@ndm.edu; (410) 532-5308

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. Submit forms via mail (4701 N. Charles St, Baltimore, MD 21210), email (studentlife@ndm.edu), fax (410-532-5764), or in person to the Division of Student Life.
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 ❑ International (If so, Country of Origin) ____________

School: Arts&Sciences_____ Education_____ Nursing_____ Pharmacy _____

Perminent 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 son/daughter 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.

	Dose I	Dose 2
MMR	___/___/___ M D YYYY	___/___/___ M D YYYY

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

OR

	Dose I	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 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 Loss Yes ❑ No ❑	Weakness or Fatigue Yes ❑ No ❑	If "YES", explain:

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

SECTION D (Recommended 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 I	___/___/___ 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 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 OR ACCEPTABLE DOCUMENTATION

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 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.