ST MARY'S COLLEGE of MARYLAND
The National Public Honors College

Wellness Center Health Services – Immunization Record

DUE: August 1st (Fall admission)
December 15th (Spring admission)

HIGHLY RECOMMENDED IMMUNIZATIONS:

To be completed and signed by your health care provider.
Once signed and completed, upload to your SMCM Health Record.

Student Name: ____ Date of Birth: ______________

MMR – Measles, Mumps Rubella — Two doses required or a blood titer to show immunity to the disease.

MMR Dose #1: Date ____/____/_______ MMR Dose #2: Date ____/ ____/ _______

OR

Lab test proving immunity (attach lab reports)

Measles ☐ Immune – Date ____/ ____/ _______ Titer value: Negative / Positive
Mumps ☐ Immune – Date ____/ ____/ _______ Titer value: Negative / Positive
Rubella ☐ Immune – Date ____/ ____/ _______ Titer value: Negative / Positive

Tdap – TETANUS-DIPTHERIA-PERTUSSIS — Td (Tetanus-diphtheria) does not satisfy this requirement.

Must be given at age 11 or older.

Tdap Date ____/ ____/ _______

Meningococcal Vaccine — Under Maryland State law, students who reside on-campus are required to have one of the 4-valent (ACYW) meningococcal conjugate vaccine given at age 16 or older, or you must submit an exemption.

Meningitis Vaccine Date____/ ____/ _______
☐ Menactra (MCV4) ☐ Menomune (MPSV4) ☐ Meningococcal (unspecified)

☐ Exemption – Must complete Exemption form and submit with Immunization Record.

Covid-19 +Booster Vaccine

Dose #1: Date ____/ ____/ _______ Manufacturer: ☐Moderna ☐Pfizer ☐Johnson&Johnson ☐Other
Dose #2: Date ____/ ____/ _______ Manufacturer: ☐Moderna ☐Pfizer ☐Johnson&Johnson ☐Other
Booster Dose #1: Date ____/ ____/ _______ Manufacturer: ☐Moderna ☐Pfizer ☐Johnson&Johnson ☐Other
*Booster Dose #2: Date ____/ ____/ _______ Manufacturer: ☐Moderna ☐Pfizer ☐Johnson&Johnson ☐Other
*Booster Dose #3: Date ____/ ____/ _______ Manufacturer: ☐Moderna ☐Pfizer ☐Johnson&Johnson ☐Other
(*If applicable)

☐ Exemption – Must complete Exemption form and submit with Immunization Record.

Student Name: ____ Date of Birth: _______________

Tuberculosis Screening

☐ No ☐ Yes Have you ever had close contact with persons known or suspected to have active tuberculosis?

☐ No ☐ Yes Have you ever been a resident, employee, or volunteer in a high-risk congregate setting (e.g. correctional facility, long-term care facility, or homeless shelter)?

☐ No ☐ Yes Have you ever been a volunteer or health care worker who served clients at increased risk for active tuberculosis?

☐ No ☐ Yes Have you been born in or spent 4 consecutive weeks or longer in any of the following areas with a high incidence rate of tuberculosis?

If you answered 'NO' to ALL of the questions, no further testing required.
If you answered 'YES' to **ANY** of the questions, the below TB skin **OR** blood test is REQUIRED and to be completed by your provider.

Afghanistan	Cabo Verde	Fiji	Lao	Namibia	Sao Tome &	Uganda
Algeria	Cambodia	French Polynesia	Latvia	Nauru	Principe	Ukraine
Angola	Cameroon	Gabon	Lesotho	Nepal	Senegal	Uruguay
Anguilla	Central African	Gambia	Liberia	Nicaragua	Sierra Leone	Uzbekistan
Argentina	Republic	Georgia	Libya	Niger	Singapore	Vanuatu
Armenia	Chad	Ghana	Lithuania	Nigeria	Solomon	Venezuela
Azerbaijan	China	Greenland	Madagascar	Niue	Islands	Vietnam
Bangladesh	Colombia	Guam	Malawi	Northern Mariana	Somalia	Yemen
Belarus	Comoros	Guatemala	Malaysia	Islands	South Africa	Zambia
Belize	Congo	Guinea (Bissau)	Maldives	Pakistan	Sri Lanka	Zimbabwe
Benin	Côte d'Ivoire	Guyana	Mali	Palau	Sudan	
Bhutan	Djibouti	Haiti	Malta	Panama	Suriname	
Bolivia	Dominica	Honduras	Marshall Islands	Papua	Tajikistan	
Bosnia &	Dominican	India	Mauritania	New Guinea	Tanzania	
Herzegovina	Republic	Indonesia	Mexico	Paraguay	Thailand	
Botswana	Ecuador	Iraq	Micronesia	Peru	Timor-Leste	
Brazil	El Salvador	Kazakhstan	Moldova	Philippines	Togo	
Brunei	Equatorial Guinea	Kenya	Mongolia	Qatar	Tokelau	
Darussalam	Eritrea	Kiribati	Morocco	Romania	Tunisia	
Burkina Faso	Eswatini	Korea	Mozambique	Russia	Turkmenistan	
Burundi	Ethiopia	Kyrgyzstan	Myanmar	Rwanda	Tuvalu	

Tuberculosis Skin Test Date of Test: _____/ _____/ ________ Date of Result: _____/ _____/ ________
Results: Negative / Positive

OR

Quanti-FERON Blood Test Date of Test: _____/ _____/ ________ Date of Result: _____/ _____/ ________
Results: Negative / Positive

Chest X-ray Date of X-ray: _____/ _____/ ________ Date of Result: _____/ _____/ ________
(required if current or previous TST or QFT test is positive):
Results: Normal / Abnormal

Student Name: ____ Date of Birth: ______________

Recommended Immunizations / Vaccines for ALL Students

Hepatitis A Two Dose Series
Dose #1: Date ____/ ____/ _______
Dose #2: Date ____/ ____/ _______

Hepatitis B Three Dose Series
Dose #1: Date ____/ ____/ _______
Dose #2: Date ____/ ____/ _______
Dose #3: Date ____/ ____/ _______

HPV – Human Papillomavirus / Gardasil
Dose #1: Date ____/ ____/ _______
Dose #2: Date ____/ ____/ _______
Dose #3: Date ____/ ____/ _______

Meningitis B ☐ Bexero ☐ Trumenba
Dose #1: Date ____/ ____/ _______
Dose #2: Date ____/ ____/ _______
Dose #3: Date ____/ ____/ _______

Varicella – Chicken Pox Two Dose Series **OR** Date of Contraction (approximate)
Dose #1: Date ____/ ____/ _______ Contraction Date: ____/ ____/ _______
Dose #2: Date ____/ ____/ _______

Influenza Vaccine – Seasonal Flu
Date: ____/ ____/ _______

☐ I have reviewed/verified the information provided on all three (3) pages with the patient to be true and accurate to the best of my knowledge.

Provider Address: ____ Phone: ________________

____

Provider Name: ____

Provider Signature: ____ Date: ________________