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

Health Services Immunization Form

DUE DATES:

August 1st (Fall admission)

December 15th (Spring admission)

Legal Name: _____**Date of Birth**: _____**Student ID: _____**

SECTION A:
REQUIRED VACCINES

Meningococcal Quadrivalent Under Maryland law, students are required to have one quadrivalent conjugate meningococcal vaccine given at age 16 or older before moving into campus housing.

Date of last booster _____/ _____/ _____

☐ Waiver requested (if checked, you must complete a *Meningococcal Vaccine Waiver* form)

Measles/Mumps/Rubella (MMR) All college students born after 1956 are required to have 2 doses of the MMR vaccine and/or lab evidence of disease. Those born before 1957 without other evidence of immunity should receive one dose: two doses in an outbreak.

MMR Dose #1: Date _____/_____/_____ MMR Dose #2: Date _____/ _____/ _____

OR

Measles Dose #1: Date _____/_____/_____ MMR Dose #2: Date _____/ _____/ _____

Mumps Dose #1: Date _____/_____/_____ MMR Dose #2: Date _____/ _____/ _____

Rubella Dose #1: Date _____/_____/_____

OR

Laboratory proof (blood titer) showing positive immunity to Measles/Mumps/Rubella. If titers are negative or equivocal, the student will need to receive 2 doses of MMR at least 28 days apart. No titer is required after the MMR vaccine series.

Measles lab confirmation of positive immunity: Date_____/ _____/ _____

Mumps lab confirmation of positive immunity: Date_____/ _____/ _____

Rubella lab confirmation of positive immunity: Date_____/ _____/ _____

☐ Waiver requested (if checked, you must complete a *Measles, Mumps and Rubella Vaccine Waiver* form)

SECTION B:
RECOMMENDED VACCINES

COVID-19

Monovalent primary series:

Dose #1: Date _____/ _____/ _____ Manufacturer: ☐Moderna ☐Pfizer ☐Johnson&Johnson ☐Other_____

Dose #2: Date _____/ _____/ _____ Manufacturer: ☐Moderna ☐Pfizer ☐Johnson&Johnson ☐Other_____

Monovalent booster(s):

Booster #1: Date _____/ _____/ _____ Manufacturer: ☐Moderna ☐Pfizer ☐Johnson&Johnson ☐Other_____

Booster #2: Date _____/ _____/ _____ Manufacturer: ☐Moderna ☐Pfizer ☐Johnson&Johnson ☐Other_____

Booster #3: Date _____/ _____/ _____ Manufacturer: ☐Moderna ☐Pfizer ☐Johnson&Johnson ☐Other_____

Bivalent (as a primary dose or booster):

Dose #1: Date _____/ _____/ _____ Manufacturer: ☐Moderna ☐Pfizer

Dose #2: Date _____/ _____/ _____ Manufacturer: ☐Moderna ☐Pfizer

Hepatitis A
Dose #1: Date _____/ _____/ _____
Dose #2: Date _____/ _____/ _____

Hepatitis B
Dose #1: Date _____/ _____/ _____
Dose #2: Date _____/ _____/ _____
Dose #3: Date _____/ _____/ _____

Human Papillomavirus (HPV)
Dose #1: Date _____/ _____/ _____
Dose #2: Date _____/ _____/ _____
Dose #3: Date _____/ _____/ _____

Influenza
Date: _____/ _____/ _____

Polio
Primary series completed? ☐ Yes☐ No
Date of last dose of series: _____/ _____/ _____

Serogroup B Meningococcal
☐ Bexsero (2 doses) **OR** ☐ Trumenba (2 or 3 doses)
Dose #1: Date _____/ _____/ _____ Dose #1: Date _____/ _____/ _____
Dose #2: Date _____/ _____/ _____ Dose #2: Date _____/ _____/ _____
Dose #3: Date _____/ _____/ _____

Tetanus/Diphtheria/Pertussis (Tdap)
Primary series completed? ☐ Yes☐
Date of last Tdap booster: _____/ _____/ _____
If tetanus ONLY was received (which is uncommon), date of last booster: _____/ _____/ _____

Varicella
Dose #1: Date _____/ _____/ _____
Dose #2: Date _____/ _____/ _____
OR
History of disease? ☐ Yes☐ No
OR
Born in the U.S. before 1980? ☐ Yes☐ No

SECTION C:
TUBERCULOSIS SCREENING

The following questions are to be completed by the student:

Yes ☐ No ☐ Have you ever had close contact with persons known or suspected to have active tuberculosis?
Yes ☐ No ☐ Have you ever been a resident, employee, or volunteer in a high-risk congregate setting (e.g., correctional facility, long-term care facility, homeless shelter)?
Yes ☐ No ☐ Have you ever been a volunteer or health care worker who served clients at increased risk for active tuberculosis?
Yes ☐ No ☐ 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 (areas listed below)?

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

If you answered NO to ALL the above questions, no further testing is required.
If you answered YES to ANY of the questions, then a Tuberculosis skin test OR blood test is REQUIRED.

The following test(s) are to be completed by a healthcare provider if the student answered YES to any of the above questions:

Tuberculosis Skin Test Date of Test: _____/ _____/ _____ Results: ☐Negative ☐ Positive

OR

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

Chest X-ray (required if current or previous TST or QFT test is positive):

Date of X-ray: _____/ _____/ _____ Results: ☐ Normal ☐Abnormal

I have reviewed the information provided on all three (3) pages with the patient and verify that this information is accurate to the best of my knowledge.

Provider Name: _____ Provider Signature: _____ Date: _____

Provider Address: _____ Phone: _____

_____

Official office stamp:

STUDENT: Once signed by your healthcare provider, upload this form along with the Demographic and Consent form, Health Questionnaire form, and any Vaccination Waiver form(s) into your SMCM Health Record.
https://www.smcm.edu/wellness/

A copy of your immunization record will not be accepted; this form MUST be completed