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: ______________________________ **Preferred Name** ________________ **Pronouns** __________

Date of Birth: ____ /____ /____ **Biologic Sex Assigned at Birth** __________ **Student ID:** _____________

SECTION A:
REQUIRED VACCINES

Meningococcal

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 ____/ ____/ _____ ☐ MenACWY **OR** ☐ MenABCWY

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

Measles/Mumps/Rubella

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) indicating proof of 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

The Centers for Disease Control and Prevention along with the Advisory Committee on Immunization Practices continue to adapt their vaccine recommendations. "Up to date" is currently defined as receiving one dose of an updated COVID-19 vaccine. However, people who are moderately or severely immunocompromised may get additional updated COVID-19 vaccine doses.

Did you receive Pfizer or Moderna vaccines before 9/12/23, or Novavax before October 3, 2023? ☐ Yes ☐ No

Updated vaccine:

Date: ____/ ____/ ____ ☐ Moderna ☐ Pfizer ☐ Novavax

Additional dose(s), if applicable:

Date: ____/ ____/ ____ ☐ Moderna ☐ Pfizer ☐ Novavax Date: ____/ ____/ ____ ☐ Moderna ☐ Pfizer ☐ Novavax

Hepatitis A

Dose #1: Date ____/ ____/ ______

Dose #2: Date ____/ ____/ ______

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

Human Papillomavirus
Dose #1: Date _____/ _____/ ______
Dose #2: Date _____/ _____/ ______
Dose #3: Date _____/ _____/ ______

Influenza
Date: _____/ _____/ _____

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

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

Tetanus/Diphtheria/Pertussis
Primary 4-dose series completed? ☐ Yes ☐ No
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
Laboratory proof (blood titer) indicating proof of immunity to varicella. If the titers are negative or equivocal, the student will need to repeat the varicella series with doses at least 4 weeks apart. No titer is required after the varicella vaccine series is complete.

Monkeypox
Dose #1: Date _____/ _____/ ______
Dose #2: Date _____/ _____/ ______

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

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

Interferon Gamma Release Assay (QuantiFERON-TB Gold *OR* T-Spot TB)

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

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

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

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

Provider Name: ____________________________________ Provider Signature: ___________________________________ Date: __________

Provider Address: ____ Phone: ______________________________

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OFFICIAL OFFICE STAMP:

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

No other immunization forms will be accepted