**Immunization & Medical History**

**University of Maryland, Baltimore - Student Health**

408 W Lombard St, Lower Level, Baltimore, MD 21201

Ph: 667-214-1883 Fax: 410-685-1962 or 3142

[shealth@som.umaryland.edu](mailto:shealth@som.umaryland.edu)

\*\*This form is *optional* and only to help you organize your immunization records. \*\*

You can upload this form or your personal vaccine records/titer results directly to Complio ADB

**\*\*Please use the following link to upload your documents:** [https://umaryland.complio.com/ssoprehandler.aspx](https://nam11.safelinks.protection.outlook.com/?url=https%3A%2F%2Fumaryland.complio.com%2Fssoprehandler.aspx&data=05%7C01%7CHEInegbenosun%40som.umaryland.edu%7C267892a8e73f4cd87db908db773f0d8c%7C717009a620de461a88940312a395cac9%7C0%7C0%7C638234884909957592%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=udV5MNg2QVyDjWGrOxuku0Vdtm0%2FEUeQnAjV%2B5Lw94w%3D&reserved=0). **\*\***

|  |
| --- |
| Last Name (Print) First Name Middle Name Student @ number |
| Date of Birth Sex Email Address  Local Address City State Zip Code  Preferred Phone number Other phone |

Start Date of Program: Fall Spring Summer 20\_\_\_\_\_

Select below which program you are entering (check one):

|  |  |
| --- | --- |
| Dental Dental Hygiene PG Dental | Medicine |
| Graduate School (PhD/MS) | Pathology Assistant |
| Genetic Counseling | Law |
| Physical Therapy | Medical Research Technology |
| Pharmacy | Social Work MSW |
| Nursing BSN/MSN/DNP |  |

**Items A-F are the University of Maryland Baltimore campus requirements.**

Please upload documentation to Complio ADB: [https://umaryland.complio.com/ssoprehandler.aspx](https://nam11.safelinks.protection.outlook.com/?url=https%3A%2F%2Fumaryland.complio.com%2Fssoprehandler.aspx&data=05%7C01%7CHEInegbenosun%40som.umaryland.edu%7C267892a8e73f4cd87db908db773f0d8c%7C717009a620de461a88940312a395cac9%7C0%7C0%7C638234884909957592%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=udV5MNg2QVyDjWGrOxuku0Vdtm0%2FEUeQnAjV%2B5Lw94w%3D&reserved=0).

1. **Td**  or **Tdap** (Must be within 10 years) ………………………………………………. Date: \_\_\_/\_\_\_/\_\_\_

Student Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB \_\_\_\_\_\_\_\_\_ @Number\_\_\_\_\_\_\_\_\_\_\_

1. **MMR (Measles, Mumps, Rubella) 2 Doses Required or Proof of titers**

………………………………………………………………………………………………….. Dates of vaccine: \_\_\_/\_\_\_/\_\_\_ \_\_\_/\_\_\_/\_\_\_

1. Measles (Rubeola)

Titer Date: \_\_\_/\_\_\_/\_\_\_ Result\_\_\_\_\_\_\_\_\_ Immune/ Not immune

Booster if not immune: \_\_\_/\_\_\_/\_\_\_\_

1. Rubella

Titer Date: \_\_\_/\_\_\_/\_\_\_ Result\_\_\_\_\_\_\_\_\_ Immune/ Not immune

Booster if not immune: \_\_\_/\_\_\_/\_\_\_\_

1. Mumps

Titer Date: \_\_\_/\_\_\_/\_\_\_ Result\_\_\_\_\_\_\_\_\_ Immune/ Not immune

Booster if not immune: \_\_\_/\_\_\_/\_\_\_\_

1. **Varicella (chickenpox)** **2 Doses Required or Proof of titer**

………………………………………………………………………………………………… Dates of vaccine: \_\_\_/\_\_\_/\_\_\_ \_\_\_/\_\_\_/\_\_\_

Titer Date: \_\_\_/\_\_\_/\_\_\_ Result\_\_\_\_\_\_\_\_\_ Immune/ Not immune

Booster if not immune: \_\_\_/\_\_\_/\_\_\_\_

1. **Hepatitis B (Not required for Law Students) \*2 Dose/3 Dose Vaccine Required AND Proof of titer\***

………………………………………………………………………… Dates of vaccine: \_\_\_/\_\_\_/\_\_\_ \_\_\_/\_\_\_/\_\_\_ \_\_\_/\_\_\_/\_\_\_

Titer Date \_\_\_/\_\_\_/\_\_\_ Result \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Immune/Not immune

If not immune 2nd Hepatitis B series: \_\_\_/\_\_\_/\_\_\_ \_\_\_/\_\_\_/\_\_\_

\*\*\*Immunization series CAN be completed while at school\*\*\*

1. Meningococcal Vaccine. Do you plan to live in UMB Student housing (Fayette Square or Pascault Row)? If yes, provide MCV vaccine date or attach waiver. Date of Vaccine: \_\_\_/\_\_\_/\_\_\_ \*Must be within 5 years of entry
2. **Tuberculosis** You must provide either a TB Gold/Tspot blood test or proof of one tuberculosis skin tests (TST) within the last 12 months **AND** an Annual Tuberculosis Risk Questionnaire. The preferred method of screening is the TB Gold/Tspot test.

TB Gold/Tspot Blood Test Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Positive Negative

**TST**

Placement Date \_\_\_\_\_\_\_\_\_\_ Read Date \_\_\_\_\_\_\_\_

Result (mm of induration) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Readers Signature and Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If positive, attach Chest X-Ray, AND UMB Student Symptom Based TB Screening Questionnaire. Was latent TB treatment offered? Yes No | Dates of treatment: \_\_\_\_\_\_\_\_\_\_Treatment Regimen\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. COVID-19 Vaccine: Primary Series Required. Type:\_\_\_\_\_\_\_\_\_\_\_ Dates of Vaccine: \_\_\_/\_\_\_/\_\_\_ \_\_\_/\_\_\_/\_\_\_

Must upload vaccine lot # and dates to UMB COVID Management Portal: https://www.umaryland.edu/coronavirus/vaccine/

**HEALTHCARE PROVIDER SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Print Healthcare provider Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Office phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\*Your school/program may have additional compliance requirements. Please contact school/program administrators to confirm.*