UNIVERSITY OF NEW ENGLAND

Student Health Services

Immunization Form

for Colleges of Health Professions

University of New England and State of Maine Requirements

Name: _____Date of Birth _____
Home Address: _____City:_____State:_____Zip:_____
Cell: _____Home: _____

COLLEGES of: Health Professions:
College of Osteopathic Medicine, College of Dental Medicine, College of Pharmacy, Nursing, Applied Exercise Science, Athletic Training, Sports Medicine, Dental Hygiene, Physical Therapy, Occupational Therapy, Physician's Assistant, Social Work and MSNA.

Meningococcal Vaccine: (Residential Students Only) Date Administered _____

TDAP: Date Administered _____

Hepatitis B Series: (Three shot series) **(HEP B TITER REQUIRED)**

Dates Administered: #1 _____ #2 _____ #3 _____

Hepatitis B Surface Antibody Titer
Titer Date _____ Result: **Attach Laboratory Values**
***If titer is NEGATIVE, repeat the Hepatitis B series and follow-up with a repeat titer in 6-8 weeks ***

MMR Series: (Two shot series)
(MMR Titer Required if no documentation of 2 immunizations)

Dates Administered: #1 _____ #2 _____
MMR Antibody Titer
Titer Date:_____ Result: **Attach Laboratory Values**

Varicella Series: (Two shot series) Dates Administered: #1 _____ #2 _____
Positive Varicella Titer: Date_____
Proof of Chickenpox (Varicella) immunity.
Either: a. A positive serological test for immunity **Attach Laboratory Values** OR
b. Documentation of vaccinations (series of 2)

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Tuberculosis Skin Test: Two step TB Testing is required within the year of the start date and updated annually. The second PPD must be placed no earlier than 14 days after the first test. (a) [ ] History of childhood BCG vaccination (date: _____) (b) [ ] Prior skin test consistent with latent TB Type and date: _____ # mm induration: _____ Antibiotic therapy and dates: _____ Date of chest X-ray (attach report): _____ **If you checked A or B a System Review is required** **Form is located on website**	**Step 1** Date Placed: _____ Date Read_____ # mm induration:_____ [ ] negative [ ] consistent with latent TB **Step 2** Date Placed: _____ Date Read_____ # mm induration:_____ [ ] negative [ ] consistent with latent TB If consistent with latent TB, report date of chest X-ray and attach report: _____ Record antibiotic therapy, if taken, and dates:

Please mail or fax forms to Student Health Services at the appropriate campus

11 Hills Beach Rd
Biddeford, ME 04005
Tel: (207) 602-2358
Fax: (207) 602-5904

716 Stevens Ave.
Portland, ME 04103
Tel: (207) 221-4242
Fax: (207) 523-1913

IMMUNIZATIONS DUE:

Spring Semester due: January 1st
Fall Semester due: July 1st
Winter Semester due: Oct 1st

Summer Semester due: April 1st
COM Semester due: June 1st

Health Care Provider Signature/Stamp (REQUIRED):

_____ _____
Signature of Health Care Provider Date

_____ _____
Printed/Typed Name of Health Care Provider Telephone Number