College of Arts and Sciences
Immunization Form
University of New England and State of Maine Requirements

Name: ______________________________________ Date of Birth __________________
Home Address: __________________________________ City:________________ State:_______ Zip:________
Cell: ___________________________ Home: ______________________________

COVID-19 Vaccine: Dates Administered: #1 _________ #2 _________
MMR Series: (Two shot series)
Dates Administered: #1 __________ #2 __________
MMR Titer Required ONLY if unable to provide documentation of 2 immunizations.
MMR Antibody Titer: Date:_________ Result: Laboratory report MUST be attached
*If titer proves NEGATIVE or EQUIVOCAL, then two administrations of the vaccine are required.
Tdap Vaccine: Date Administered: __________

Meningococcal Vaccine: (Residential Students Only) Date Administered: __________

The information provided is for the University of New England Health Center use and/or for proof of compliance for educational affiliates. This examination/immunization record is correct according to available records.

Upload completed form to our Patient Portal https://une.medicatconnect.com/
or mail/fax form to the Student Health Center at the appropriate campus
11 Hills Beach Rd 716 Stevens Ave.
Biddeford, ME 04005 Portland, ME 04103
Tel: (207) 602-2358 Tel: (207) 221-4242
Fax: (207) 602-5904 Fax: (207) 523-1913

IMMUNIZATIONS DUE:
Spring Semester due: January 1st
Fall Semester due: July 1st
Health Care Provider Signature/Stamp (REQUIRED):

______________________________________    _________________________
Signature of Health Care Provider     Date

______________________________________    _________________________
Printed/Typed Name of Health Care Provider    Telephone Number

Revised: 03/17, 3/19, 6/21