



College of Osteopathic Medicine

Immunization Form

University of New England and State of Maine Requirements

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Cell: \_\_\_\_\_ Home: \_\_\_\_\_

College of Osteopathic Medicine

**COVID-19 Vaccine:** Vaccine type \_\_\_\_\_ Dates Administered: #1 \_\_\_\_\_ #2 \_\_\_\_\_  
Booster date \_\_\_\_\_  
**Tdap Vaccine:** Date Administered: \_\_\_\_\_  
**Meningococcal Vaccine:** Date Administered: \_\_\_\_\_  
**Flu Vaccine: Date Administered \_\_\_\_\_ (must be done yearly)**

**Hepatitis B Series:** (Three shot series) **AND**  
**Hepatitis B Surface Antibody Titer, IgG, Quantitative**  
Dates Administered: #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_  
**Hepatitis B Antibody Titer, IgG, Quantitative:** Result: Laboratory report **MUST** be attached.  
\*If titer proves **NEGATIVE** or **EQUIVOCAL**, a repeat of the Hepatitis B series of 3 vaccines is required.

**MMR Series:** (Two shot series with the first dose occurring after the student’s 1st birthday, with at least 28 days between doses)  
Dates Administered: #1 \_\_\_\_\_ #2 \_\_\_\_\_  
**If you are unable to demonstrate a two shot series for MMR, then you will need a MMR Antibody Titer, Qualitative:** Result: Laboratory report **MUST** be attached.  
\*If titer proves **NEGATIVE** or **EQUIVOCAL**, then two administrations of the vaccine are required.

**Varicella Series:** (Two shot series with the first dose occurring after the student’s 1st birthday, with at least 28 days between doses)  
Dates Administered: #1 \_\_\_\_\_ #2 \_\_\_\_\_  
**If you are unable to demonstrate a two shot series for Varicella, then you will need a Varicella Antibody Titer, Qualitative:** Result: Laboratory report **MUST** be attached.  
\*If titer proves **NEGATIVE** or **EQUIVOCAL**, then two administrations of the vaccine are required.



**College of Osteopathic Medicine**

**Immunization Form**

University of New England and State of Maine Requirements

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

<p style="text-align: center;"><b>Tuberculin Testing</b></p> <p>Tuberculosis testing is required within one year prior to UNE start date. Either a TB blood test (QuantiFERON®-TB Gold or T-SPOT® TB) OR a 2-step PPD (TST) are acceptable.</p> <p style="text-align: center;"><b>If you check A or B below</b></p> <p><b>An Annual Tuberculosis Symptom Assessment is required</b> <a href="http://www.une.edu/studentlife/shc">http://www.une.edu/studentlife/shc</a></p> <p><b>A-</b> <input type="checkbox"/> Prior positive tuberculin skin test</p> <p><b>B-</b> <input type="checkbox"/> History of latent TB</p> <p>Record antibiotic therapy, if taken:        Start Date: _____        Date of Completion: _____        Date of chest X-ray (attach report): _____</p>	<p><b>TB Blood test results- circle results and upload test results to Medicat</b></p> <p style="padding-left: 20px;">Positive Negative Intermediate</p> <p><b>Two-Step Tuberculin Skin Test</b></p> <p><b>Step 1</b>        Date Placed: _____        Date Read: _____        # mm induration: _____  <input type="checkbox"/> negative <input type="checkbox"/> consistent with latent TB</p> <p style="text-align: center;"><b>Repeat 7 to 21 days after step 1</b></p> <p><b>Step 2</b>        Date Placed: _____        Date Read: _____        # mm induration: _____  <input type="checkbox"/> negative <input type="checkbox"/> consistent with latent TB</p>
----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

**Please upload required information to our patient portal:**  
<https://une.medicatconnect.com/>  
 Student Health Center  
 11 Hills Beach Road  
 Biddeford, Maine 04005  
 Tel: (207) 602-2358

**REQUIREMENTS DUE**

**May 15<sup>th</sup>**

**Health Care Provider Signature/Stamp (REQUIRED):**

\_\_\_\_\_  
Signature of Health Care Provider

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed/Typed Name of Health Care Provider

\_\_\_\_\_  
Telephone Number