Immunization Form
University of New England and State of Maine Requirements

Name: __________________________________________________ Date of Birth __________________
Home Address: ______________________________ City:________________ State:_______ Zip:________
Cell: _____________________________________ Home: _____________________________________

College of Arts and Sciences

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: __________

COVID-19 Vaccine: Vaccine type ________ Dates Administered: #1 _________ #2 ________
Booster date ________

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

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
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

Summer Semester due: April 1st
Winter Semester due: Oct 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, 3/22