



Colleges of Health Professions

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: Vaccine type _____ Dates Administered: #1 _____ #2 _____
Booster date _____
Tdap Vaccine: Date Administered: _____
Meningococcal Vaccine: (Residential Students Only) Date Administered: _____

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.



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<p style="text-align: center;">Tuberculin Testing</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;">If you check A or B below</p> <p>An Annual Tuberculosis Symptom Assessment is required http://www.une.edu/studentlife/shc</p> <p>A- <input type="checkbox"/> Prior positive tuberculin skin test</p> <p>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>TB Blood test results- circle results and upload test results to MedicaT</p> <p style="padding-left: 20px;">Positive Negative Intermediate</p> <p>Two-Step Tuberculin Skin Test</p> <p>Step 1 Date Placed: _____ Date Read: _____ # mm induration: _____ <input type="checkbox"/> negative <input type="checkbox"/> consistent with latent TB</p> <p style="text-align: center;">Repeat 7 to 21 days after step 1</p> <p>Step 2 Date Placed: _____ Date Read: _____ # mm induration: _____ <input type="checkbox"/> negative <input type="checkbox"/> consistent with latent TB</p>
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Please upload required information to our patient portal:

<https://une.medicatconnect.com/>

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
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IMMUNIZATIONS DUE:

Spring Semester due: December 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