



DIVISION OF
STUDENT AFFAIRS
UNIVERSITY HEALTH CENTER
IMMUNIZATION RECORD

Please submit your immunization information ONLINE no later than the first day of class

Instructions for uploading immunizations:

- Step 1: Go to www.myuhc.umd.edu
Step 2: Enter your **directory ID** and **password** to log on, then enter your **UID** (University ID) in the box and hit ENTER
Step 3: Click on **Forms** (located on the left hand side of the page), then click on **Immunizations** (in the middle of the page)
Step 4: Carefully enter your immunization dates in the appropriate fields
Step 5 : Scroll down to the gray box and click "Add Immunization Record" to attach your **supporting documentation**.

You can scan or take a photo of the documents which can then be uploaded.

You may save your entries and return to them later, but once you click Submit Final, you will not be able to make changes

Submit this form with your provider's signature as **supporting documentation**.

If your provider does not sign this form, you must attach ONE of the following alternative forms of **supporting documentation**:

1. Vaccine record from your doctor/provider office that includes provider information
2. Up to date school or university immunization record
3. Provider signed proof of current or previous immunizations
4. Active duty (DD214) status in the US Military or International W.H.O Yellow Book showing MMR dates (completed by a medical provider)

We ask that supporting documentation please be in English

If you are in need of required vaccines, these are available at the University Health Center.

Please call for an appointment when you arrive on campus. Many insurances can be billed for the cost of the vaccines.

*The University of Maryland requires that **ALL students** including credit/non-credit, degree/non-degree seeking, full-time/part-time, graduate/undergraduate, transfer and international students complete this form.

****Allow one week for processing after your form has been submitted.**

****Once your form has been processed, you will receive a secure message by email.**

****Student registration will be blocked if immunization information is missing.**

***Regarding the Mandatory Health Insurance Waiver:** Submission of this form does not meet the Mandatory Health Insurance Waiver Requirement! Evidence of insurance must be provided yearly online at www.firststudent.com.

PLEASE PRINT LEGIBLY IN BLUE OR BLACK INK.

Name (Last)	JOSHI	First	ARPIT
University ID#	117008456	Date of Birth (mm/dd/yyyy)	03/28/1998
Cell phone number:		Email Address:	ARPITJ@UMD.EDU
What is your home country?	INDIA		

Parental/Guardian Consent (for students under age 18):

I give permission for such diagnostic and therapeutic procedures as may be deemed necessary for my student until they turn 18. The Health Center will seek to notify parents in the event of an emergency.


Signed

Relationship

Date

Last name JOSHIUNIVERSITY OF MARYLAND
IMMUNIZATION RECORDUniversity ID# 11700849

SECTION A (REQUIRED): ALL STUDENTS BORN AFTER 1956 MUST PROVIDE THIS INFORMATION

Vaccines	Dates Given/Perf	Requirements
MMR  Dose 1 <u>10</u> / <u>10</u> / <u>2019</u> mm dd yyyy Dose 2 <u>12</u> / <u>04</u> / <u>2019</u> mm dd yyyy	Requirements 2 doses of MMR -At least 4 weeks between doses -First dose given after 1st birthday -Second dose after age 4	
OR		
Individual Vaccines: -Measles -Mumps -Rubella	Measles Dose 1 ____/____/____ mm dd yyyy Dose 2 ____/____/____ mm dd yyyy Mumps Dose 1 ____/____/____ mm dd yyyy Dose 2 ____/____/____ mm dd yyyy Rubella Dose 1 ____/____/____ mm dd yyyy Dose 2 ____/____/____ mm dd yyyy	Requirements 2 doses of each individual component (2 measles, 2 mumps, 2 rubella) -At least 4 weeks between doses -First dose given after 1st birthday -Second dose after age 4
OR		
Positive blood test showing immunity	Measles titer date ____/____/____ mm dd yyyy Result _____ Mumps titer date ____/____/____ mm dd yyyy Result _____ Rubella titer date ____/____/____ mm dd yyyy Result _____	Positive titers *Lab report must be attached
AND		
Tdap	<u>10</u> / <u>10</u> / <u>2019</u> mm dd yyyy	One dose given at age 11 or later

SECTION B (REQUIRED): ALL UNDERGRADUATE STUDENTS MUST COMPLETE THIS SECTION

Meningitis (ACWY) meningo-coccal vaccine	<u>10</u> / <u>10</u> / <u>2019</u> mm dd yyyy <input type="checkbox"/> Check if waiver completed below in SECTION C	Check one <input checked="" type="checkbox"/> Menactra <input type="checkbox"/> Menveo <input type="checkbox"/> Unknown	One dose given after age 16 -May be waived by completing Section C
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YOUR DOCTOR/PROVIDER MUST SIGN HERE: Please review, sign, and stamp to verify immunization dates and information are correct.

Dr. Pankaj Bhardwaj

Clinician Signature

91-8003996903

Clinician Phone Number

10/10/2019

Date

 डॉ. पंकज भारद्वाज
 Dr. Pankaj Bhardwaj
 अतिरिक्त प्राध्यापक
 Additional Professor

 Adult Vaccination Centre,
 OPD-118, Block-B,
 AIIMS, Jodhpur-342005

 Nodal Officer
 YFVC, AIIMS, Jodhpur

 सामुदायिक चिकित्सा विभाग और परिवार चिकित्सा विभाग
 एमपीएच कार्यक्रम समन्वयक, स्कूल ऑफ पब्लिक हेल्थ
 Community Medicine & Family Medicine
 MPH Program Coordinator, SPH
 अखिल भारतीय आयुर्विज्ञान संस्थान, जोधपुर
 All India Institute of Medical Sciences, Jodhpur

SECTION C: MENINGOCOCCAL WAIVER (COMPLETE ONLY IF YOU HAVE NOT RECEIVED MENINGITIS VACCINE)

All **undergraduate** students must either be vaccinated against meningococcal disease or complete a waiver.

FOR YOUR SAFETY, WE STRONGLY RECOMMEND RECEIVING THE VACCINE

Meningitis information can be found here:

<https://phpa.health.maryland.gov/OIDEOR/IMMUN/Pages/meningococcal-disease.aspx>

Individuals 18 years of age and older may sign a written waiver choosing not to be vaccinated against meningococcal disease. For individuals under 18 years of age, the parent or guardian of the individual must review the information on the risks of the disease, and sign this waiver that he/she has chosen not to have the child vaccinated.

- ☐ I have reviewed information on the risk of meningococcal disease and the effectiveness and availability of the vaccine.
- ☐ I understand that meningococcal disease is a rare but life-threatening illness.
- ☐ I understand that Maryland law requires that an individual enrolled in an institution of higher education in Maryland and who resides in campus student housing shall receive vaccination or sign this waiver.

I am 18 years of age or older and I choose to waive receipt of the meningococcal vaccine:

Signature _____

Date _____

I choose to waive receipt of the meningococcal vaccine for my child who is under 18 years of age:

Signature _____

Date _____

SECTION D: REQUIRED TUBERCULOSIS RISK SCREENING

THIS MUST BE COMPLETED BY ALL STUDENTS ONLINE AT WWW.MYUHC.UMD.EDU

If you answered YES to any questions on the Tuberculosis Risk Screening, you are required to provide the following:

Quantiferon Gold Test or T-Spot *Test MUST BE PERFORMED IN THE US* (PPD will not be accepted)	Date of blood test ____/____/____ mm dd yyyy	*You must attach laboratory report* Test must have been performed within the past 12 months Result _____
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If the result of the Quantiferon Gold or T-Spot is POSITIVE, your doctor should discuss treatment for latent TB.

Provide documentation of this review, even if you decline treatment, and your provider must complete the following:

Clinical evaluation: ☐ Normal (absence of cough, hemoptysis, fever, chills, sweats, weight loss).
☐ Abnormal (describe): _____

Chest X-ray	Date of X-ray (must be within 1 year) ____/____/____ mm dd yyyy	Attach X-ray report in English Result _____
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Treatment for latent TB (check one) ☐ Patient completed full course of treatment for latent TB.
***Attach additional clinical info** Medication and dates _____
if indicated. ☐ Patient did not complete treatment for latent TB.
Reason: _____

YOUR DOCTOR/PROVIDER MUST SIGN HERE: Please review, sign, and stamp to verify that the information above is correct.

Clinician name (MD/NP/PA)	Clinician Signature	Clinician Phone Number	Date
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Last name JOSHIUNIVERSITY OF MARYLAND
IMMUNIZATION RECORDUniversity ID# 117008456

SECTION E: RECOMMENDED VACCINES

Vaccines	Dates Given/Performed			Date of Disease
Varicella (chicken pox)	Dose 1 ____/____/____ mm dd yyyy	Dose 2 ____/____/____ mm dd yyyy	OR	____/____/____ mm dd yyyy
Hepatitis A	Dose 1 ____/____/____ mm dd yyyy	Dose 2 ____/____/____ mm dd yyyy		
Hepatitis B or Twinrix	Dose 1 ____/____/____ mm dd yyyy	Dose 2 ____/____/____ mm dd yyyy	Dose 3 ____/____/____ mm dd yyyy	
HPV	Check one: <input type="checkbox"/> Gardasil <input type="checkbox"/> Cervarix	Dose 1 ____/____/____ mm dd yyyy	Dose 2 ____/____/____ mm dd yyyy	Dose 3 ____/____/____ mm dd yyyy
Meningitis B (check one)	<input type="checkbox"/> Bexsero	Dose 1 ____/____/____ mm dd yyyy	Dose 2 ____/____/____ mm dd yyyy	
	<input type="checkbox"/> Trumenba	Dose 1 ____/____/____ mm dd yyyy	Dose 2 ____/____/____ mm dd yyyy	Dose 3 ____/____/____ mm dd yyyy
Influenza (yearly)	____/____/____ mm dd yyyy			

SECTION F: RECOMMENDED

GENDER AND IDENTITY RELATED QUESTIONS

WE ASK THESE QUESTIONS TO PREPARE TO TAKE THE BEST, INCLUSIVE CARE OF YOU
THESE QUESTIONS CAN BE COMPLETED ONLINE AT WWW.MYUHC.UMD.EDU

Thank you for completing the IMMUNIZATION RECORD!