University of Maine at PRESQUE ISLE
North of Ordinary

Immunizations Requirements

Major: _____

The following form must be completed and signed by a Medical Provider. The University of Maine at Presque Isle and Maine State Law requires that the following be completed. (Please print ledgibly.)

Student's Name _____ Date of Birth _____

1 **Diphtheria-Tetanus-Pertussis** Booster within the last 10 years. _____ Date

2 **MMR (Rubeola, Rubella, Mumps) - First dose must be after first birthday.**

Date of first dose: _____ Date of second dose (required): _____

Or split series:

MMR #1 _____ Date _____ Titer Date _____ Results

MMR #2 _____ Date _____ Titer Date _____ Results

3 **Hepatitis B Series** Injection 1 Date _____

Injection 2 Date _____

Injection 3 Date _____

Titer Results: _____ Date _____ Results

4 **Varicella Titer** _____ Date _____ Results

If titer negative (not immune), Varivax injections required

Varivax 1 _____ Date Varivax 2 _____ Date

5 Tuberculin Test (PPD)

Step 1: _____ Type _____ Date Administered _____ Signature

_____ Date Read _____ Results _____ Signature

Step 2: _____ Type _____ Date Administered _____ Signature

_____ Date Read _____ Results _____ Signature

Signature of Physician/Health Care Professional Date

University of Maine at Presque Isle
International Student Immunization Form

Completion of this form is required for every international student participating in course at the University of Maine at Presque Isle. This form must be completed by a licensed physician, nurse practitioner or physician's assistant.

Student Information

Name: _____

Date of Birth (mm/dd/yyyy): _____

Email: _____

A. Does this student have any acute or chronic health problems? If yes, Please explain:

B. Please list allergies to medications or food:

C. Date of last physical exam: _____
Results of the exam:

D. Immunization Record
To be completed by licensed health professional

1. **Rubeola** (Measles) ◯ Immune ◯ Non-Immune

   Titers date: _____ Booster date: _____

2. **Rubella** (German Measles) ◯ Immune ◯ Non-Immune

   Titers date: _____ Booster date: _____

3. **Mumps** ◯ Immune ◯ Non-Immune

   Titers date: _____ Booster date: _____

4. **OR 2 MMR's**

   Date: _____ Date: _____

Immunization Record continued *To be completed by licensed health professional*

5. Tetanus/Diphtheria (Note one d**ose in last 10 years) (note: Tdap is preferred and should be given if last Td over 2 years ago and no contraindication to vaccine)**

Vaccine Date: ◯ Td: _____ ◯ Tdap: _____

6. **Tuberculosis Screening**

PPD Mantoux: Must provide test results. If PPD positive, provide date of first positive PPD along with a negative chest x-ray.

History of BCG is not a contraindication to testing.

PPD 1: Date: _____ size (mm): _____ ◯ Negative ◯ Positive (>10mm)

For PPD Positive Only:

Chest X-ray date: _____ Result (attach report) ◯ Normal lungs ◯ other findings

Student has been counseled regarding treatment for LTBI ◯ Yes ◯ No Date: _____

Student took INH ◯ Yes ◯ No Date: _____

Student is currently free of Symptoms of TB ◯ Yes ◯ No

I have reviewed the immunization record and medical history, and examined the above named

student on _____ (date). The student is in good health, is free from evidence of communicable disease and does not pose a health risk to patients or employees at the University of Maine at Presque Isle and their clinical affiliates.

_____ _____

Practitioner's Name and Title (print) Practitioner's Signature

_____ _____

State/Country and License Number Date form was completed

Office Address: _____

_____

Telephone: _____ Email: _____

Rev. 01/13/2016