### Immunizations Requirements

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 legibly.)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Student's Name</strong></td>
<td><strong>Date of Birth</strong></td>
</tr>
</tbody>
</table>

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

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: ______________________


5. **Tetanus/Diphtheria** (Note one dose 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