UNIVERSITY OF MAINE AT AUGUSTA

IMMUNIZATION VERIFICATION FORM

To avoid having your registration access dropped, please complete and return this form or other acceptable immunization documents as soon as possible. If you have any questions regarding the requested immunization information on this form, please contact UMA at 207/621-3184 or 1-877-UMA-1234 (1-877-862-1234)

PART I:	TO BE COMPLETED BY ST	UDENT			
NAME	T. 4.07	EVENOR			
MAILING ADDRESS:	LAST	FIRST		M.I.	
	STREET/PO BOX	CITY	STATE	ZIP	
HOME PHO	NE:	WORK PHONE:			
DATE OF BI	RTH:	MaineStreet ID or last 4-d	igits of SS	I#:	
PART II:	TO BE COMPLETED AND S NOTE: History of having the di		_		
-	ANUS-DIPHTHERIA: Received tetanus-diphtheria vacc	vine within the last 10 year	rs	Month / Day / Year	
B. TWO MMR Vaccinations (MEASLES, MUMPS, RUBELLA):					
1. I	Received First (1st) MMR dose o	n		Month / Day / Year	
2. I	Received Second (2 nd) MMR dos	e on		Month / Day / Year	
C. MMR	TITER LAB REPORTS (if gi	ven instead of MMRs):			
1. N	MEASLES TITER (Lab Reports	Attached)		Month / Day / Year	
2. 1	MUMPS TITER (Lab Reports A	uttached)		Month / Day / Year	
3. I	RUBELLA TITER (Lab Reports	s Attached)		Month / Day / Year2.	

(Complete the back of form, including required signature)

PART III: EXEMPTION (If applicable)

MEDICAL EXEMPTION – TO BE CO Please explain medical exemption in for exemption.			list ending date
	SIGNATURE OF MEDICAL PR	OFESSIONA	DATE
		.1 . 11	
HEALTH CARE PROVIDER:	This section must be c	completed!	
NAME	SIGNATURE		
CLINIC NAME			
ADDRESSSTREET/PO BOX	CITY	STATE	ZIP CODE
PHONE:	DATE SIGNED		

PLEASE RETURN THIS FORM TO:

Shared Processing Center
PO Box 412 ● Bangor ME 04402
Fax: 207 / 581-5451