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 STUDENT

NAME______________________________________________________________________________

MAILING ADDRESS: __________________________________________________________________

STREET/PO BOX CITY STATE ZIP

HOME PHONE: ________________________ WORK PHONE: ______________________

DATE OF BIRTH: _____________________ MaineStreet ID or last 4 digits of SSI#: ________

PART II:  TO BE COMPLETED AND SIGNED BY A HEALTHCARE PROVIDER

NOTE: History of having the disease is not accepted proof of medical immunity.

A. TETANUS-DIPHTHERIA:
   1. Received tetanus-diphtheria vaccine within the last 10 years…___/___/___

B. TWO MMR Vaccinations (MEASLES, MUMPS, RUBELLA):
   1. Received First (1st) MMR dose on…………………………………___/___/___
   2. Received Second (2nd) MMR dose on………………………………___/___/___

C. MMR TITER LAB REPORTS (if given instead of MMRs):
   1. MEASLES TITER (Lab Reports Attached)…………………………___/___/___
   2. MUMPS TITER (Lab Reports Attached)…………………………___/___/___
   3. RUBELLA TITER (Lab Reports Attached)…………………………___/___/___

(Complete the back of form, including required signature)
PART III: EXEMPTION (If applicable)

MEDICAL EXEMPTION – TO BE COMPLETED BY A HEALTH CARE PROVIDER
Please explain medical exemption in area below. If the exemption is not permanent, please list ending date for exemption.

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SIGNATURE OF MEDICAL PROFESSIONAL DATE

HEALTH CARE PROVIDER: This section must be completed!

NAME____________________________________ SIGNATURE____________________________

CLINIC NAME ________________________________________________________________

ADDRESS ________________________________________________________________
STREET/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