UNIVERSITY OF MAINE AT AUGUSTA

IMMUNIZATION VERIFICATION FORM

To avoid having your registration access dropped, please complete and upload this form or other acceptable immunization documents to Point and Click as soon as possible. If you have any questions regarding the requested immunization information on this form, please contact UMA at 207/621-3079 or 1-877-UMA-1234 (1-877-862-1234)

PART I: TO BE COMPLETED BY STUDENT

NAME ____________________________
LAST ____________________________ FIRST ____________________________ M.I. ____________________________
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........____/____/____
      Month / Day / Year

B. TWO MMR Vaccinations (MEASLES, MUMPS, RUBELLA):

   1. Received First (1st) MMR dose on.................................____/____/____
      Month / Day / Year
   2. Received Second (2nd) MMR dose on.............................____/____/____
      Month / Day / Year

C. MMR TITER LAB REPORTS (if given instead of MMRs):

   1. MEASLES TITER (Lab Reports Attached)..........................____/____/____
      Month / Day / Year
   2. MUMPS TITER (Lab Reports Attached).............................____/____/____
      Month / Day / Year
   3. RUBELLA TITER (Lab Reports Attached)..........................____/____/____
      Month / Day / Year

(Complete the back of form, including required signature)

Rev. 9-17-21
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 __________________________

For students: Please upload to point and click through your student portal.
For healthcare providers: Please fax completed forms to 207-621-3116 or email to umaar@maine.edu.