UNIVERSITY OF MAINE AT AUGUSTA
IMMUNIZATION VERIFICATION FORM

To avoid having your registration 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: ___________________________ SOC. SEC. NUMBER: ___________________________

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.*

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

__________________________
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