Student Health Services
282 The Green
Laurel Hall
Newark, DE 19716-8101
Phone: 302-831-2226
Fax: 302-831-6407

Immunization Documentation - 2024-2025 Academic Year

Immunization documentation is due by July 25 for fall semester and January 25 for spring semester.

All incoming students, including transfer and graduate students, are required to submit immunization records. Students may submit this form, completed and signed by a licensed healthcare provider (physician, nurse practitioner, physician's assistant, or registered nurse) or other official documentation of immunization records.

*All documentation must include your name and date of birth **and be** signed and legible to be accepted.*
All documentation must be in English.

Forms should be uploaded to the UD Health Portal (https://udhealthportal.udel.edu/) or faxed to 302-831-6407.
UD Health Portal access will open in June for fall semester and in January for spring semester.

Additional information regarding required immunizations, TB screening, meningitis disease and vaccination*, and exemptions can be found on the Student Health website: https://www.udel.edu/students/health-wellbeing/records-and-billing/required-forms/

Please ensure you have completed your Tuberculosis (TB) screening questionnaire on the UD Health Portal and, if indicated, request a TB blood test from your medical provider for submission to UD.

Section 1 – To Be Completed by Student

Name: _____
Last First Middle

Date of Birth: _____ UDID #: _____

Country of Birth: _____ Date of Arrival in US (if applicable): _____

Section II – To Be Completed by Medical Provider

A. Required Vaccines

Required Vaccines

MMR *Measles, Mumps, Rubella* *(Required if born after 1956)* Two doses after age 12 months at least 28 days apart or titers	1. ____/____/_____ MM DD YY 2. ____/____/_____ MM DD YY	***OR***	MMR Titers *Lab report must be submitted for results to be accepted*	Measles ____/____/_____ MM DD YY Mumps ____/____/_____ MM DD YY Rubella ____/____/_____ MM DD YY	☐Immune ☐Non-Immune ☐Immune ☐Non-Immune ☐Immune ☐Non-Immune	
Meningococcal ACWY* Recommended for all students. **Required for 1st year students in on-campus housing.**	☐Menactra ☐MenQuadfi ☐Menveo ☐Menomune ☐Penbraya 1. ____/____/_____ MM DD YY			☐Menactra ☐MenQuadfi ☐Menveo ☐Menomune ☐Penbraya 2. ____/____/_____ MM DD YY		**At least one dose must be administered on or after 16 years of age*

Medical and Religious Vaccine Exemption Request Information can be found at https://www.udel.edu/students/health-wellbeing/records-and-billing/required-forms/

B. Required Tuberculosis (TB) Screening Questionnaire

1. Students must complete the online **TB screening questionnaire** in the "Medical Clearances" section of the UD Health Portal. (https://udhealthportal.udel.edu)
2. **If indicated on the screening questionnaire**, *provide results of a TB Blood test done no earlier than 6 months prior to enrolling.*

Type	☐T-Spot ☐QuantiFERON	**Date:**	___/___/___ MM DD YY	**Result:**	**Must include lab report** ☐Negative ☐Positive^

^Please include documentation of a normal Chest Xray done in the USA and documentation of prior TB/LTBI treatment or refusal of treatment.

Continued on next page – Medical Provider Signature Required

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C. Recommended Vaccines

These vaccines are not required for admission to the University but are strongly recommended. They may be required for specific academic programs.

Recommended Vaccines

Hepatitis A	☐ Hepatitis A ☐ Combined A/B[>]	1. ____/____/____ MM DD YY	2. ____/____/____ MM DD YY [>]3. ____/____/____ MM DD YY
Hepatitis B	☐ 3 Dose Series ☐ 2 Dose Series ☐ Combined A/B	1. ____/____/____ MM DD YY	2. ____/____/____ MM DD YY 3. ____/____/____ MM DD YY
	Hep B Surface Antibody Titer *Must submit lab report*	____/____/____ MM DD YY	☐Immune ☐Non-Immune
HPV	☐ HPV-9 ☐ HPV-4 ☐ Cervarix	1. ____/____/____ MM DD YY	2. ____/____/____ MM DD YY 3. ____/____/____ MM DD YY
Meningitis B	☐ Trumenba[+] ☐ Bexsero ☐ Penbraya	1. ____/____/____ MM DD YY	2. ____/____/____ MM DD YY [+]3. ____/____/____ MM DD YY
Polio	Completed Primary Series?	☐Yes ☐No	Booster ____/____/____ MM DD YY
Tetanus	Completed Primary Series?	☐Yes ☐No	Booster ☐Tdap ☐Td ____/____/____ MM DD YY
Varicella	1. ____/____/____ MM DD YY 2. ____/____/____ MM DD YY	Varicella Antibody Titer *Must submit lab report*	____/____/____ MM DD YY ☐Immune ☐Non-Immune
COVID-19	☐ Pfizer ☐ Moderna ☐ Novavax ☐_____	Most recent dose: ____/____/____ MM DD YY	
Other	Vaccine _____	Date ____/____/____ MM DD YY	Vaccine _____ Date ____/____/____ MM DD YY

D. Completing Medical Provider Information

Name: _____ **Credentials:** _____

Signature: _____ **Date:** _____

Address and Phone Number	

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