



## Immunization Documentation

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 (i.e. physician, nurse practitioner, physician assistant or registered nurse) or other official documentation of immunization records. Dates of immunization should be reported in MM/DD/YYYY format.

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

**Completed forms should be uploaded to the [UD Health Portal \(udhealthportal.udel.edu\)](http://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 Wellbeing Required Forms \(udel.edu/students/health-wellbeing/records-and-billing/required forms\)](http://udel.edu/students/health-wellbeing/records-and-billing/required%20forms) page.

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: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Country of Birth: \_\_\_\_\_

UDID #: \_\_\_\_\_

Date of Arrival in U.S. (if applicable): \_\_\_\_\_

***Continued on next page – Medical Provider Signature Required***



Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

## Section 2 – To be completed by medical provider

### A. Required Vaccines

#### MMR (Measles, Mumps, Rubella)

Required if born after 1956. Two doses after age 12 months at least 28 days apart or titers

MMR dose one: \_\_\_\_\_ MMR dose two: \_\_\_\_\_  
MM/DD/YY MM/DD/YY

OR

#### MMR Titers

**Please note:** Lab report must be submitted for results to be accepted.

Measles Titer: \_\_\_\_\_ Immune Non-Immune  
MM/DD/YY

Mumps Titer: \_\_\_\_\_ Immune Non-Immune  
MM/DD/YY

Rubella Titer: \_\_\_\_\_ Immune Non-Immune  
MM/DD/YY

#### Meningococcal ACWY

Recommended for all students. Required for first-year students in on-campus housing.

**Please note:** At least one dose must be administered on or after 16 years of age.

Menactra		Menactra
MenQuadfi	1. _____	MenQuadfi
Menveo	MM/DD/YY	Menveo
Menomune		Menomune
Penbraya		Penbraya
		2. _____
		MM/DD/YY

### B. Required Tuberculosis (TB) Screening Questionnaire

- Students must complete the online **TB screening questionnaire** in the “Medical Clearances” section of the [UD Health Portal](http://udhealthportal.udel.edu) (udhealthportal.udel.edu).
- If indicated on the screening questionnaire**, provide results of a TB blood test done no earlier than six months prior to enrolling.

Type: T-Spot      QuantiFERON      TB Blood Test Date: \_\_\_\_\_  
MM/DD/YY

Result (**must include lab report**):      Negative      Positive\*

\*If positive, please include documentation of a normal Chest X-ray done in the USA and documentation of prior TB/LTBI treatment or refusal of treatment.



Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

### 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.

**Hepatitis A**      Hepatitis A Combined A/B^      1. \_\_\_\_\_ MM/DD/YY      2. \_\_\_\_\_ MM/DD/YY      ^3. \_\_\_\_\_ MM/DD/YY

**Hepatitis B**      3 Dose Series      1. \_\_\_\_\_ MM/DD/YY      2. \_\_\_\_\_ MM/DD/YY      3. \_\_\_\_\_ MM/DD/YY  
2 Dose Series Combined A/B

Hep B Surface Antibody Titer (Must submit lab report)      1. \_\_\_\_\_ 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: \_\_\_\_\_ MM/DD/YY      Tdap      Td

**Varicella**      1. \_\_\_\_\_ MM/DD/YY      **Varicella Antibody Titer**      Date: \_\_\_\_\_ MM/DD/YY  
2. \_\_\_\_\_ MM/DD/YY      Must submit lab report      Immune      Non-Immune

**COVID-19**      Pfizer Moderna Novavax Other: \_\_\_\_\_      Most recent dose: \_\_\_\_\_ MM/DD/YY

**Other**      Vaccine: \_\_\_\_\_      Date: \_\_\_\_\_ MM/DD/YY      Vaccine: \_\_\_\_\_      Date: \_\_\_\_\_ MM/DD/YY

### D. Completing Medical Provider Information (MD/DO/PA/APRN/RN)

Provider Name: \_\_\_\_\_      Credentials: \_\_\_\_\_

Address: \_\_\_\_\_      Phone Number: \_\_\_\_\_

Signature: \_\_\_\_\_      Date: \_\_\_\_\_