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

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) 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) 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

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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: _____ (MM/DD/YY) MMR dose two: _____ (MM/DD/YY)

OR

MMR Titers

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

Measles Titer: _____ (MM/DD/YY) ☐ Immune ☐ Non-Immune

Mumps Titer: _____ (MM/DD/YY) ☐ Immune ☐ Non-Immune

Rubella Titer: _____ (MM/DD/YY) ☐ Immune ☐ Non-Immune

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
☐ MenQuadfi
☐ Menveo
☐ Menoumne
☐ Penbraya

1._____ (MM/DD/YY)

☐ Menactra
☐ MenQuadfi
☐ Menveo
☐ Menomune
☐ Penbraya

2._____ (MM/DD/YY)

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 (udhealthportal.udel.edu).
2. **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.

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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.

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)*
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
2. _____ MM/DD/YY

Varicella Antibody Titer *Must submit lab report* Date: _____ MM/DD/YY
☐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:_____