UNIVERSITY OF NEW ENGLAND

Student Health Center

College of Dental Medicine

Immunization Form

University of New England and State of Maine Requirements

IMMUNIZATIONS DUE:

Spring Semester due: December 1st **Summer Semester due: April 1st**
Fall Semester due: July 1st **Winter Semester due: Oct 1st**

Name: _____Date of Birth _____
Home Address: _____City: _____State: _____ Zip: _____
Cell: _____Home: _____

COVID-19 Vaccine updated: Manufacture(s): _____Date(s) : _____
Tdap Vaccine: Date Administered: _____
Meningococcal ACWY Vaccine: (Residential Students Only) Date Administered: _____
(Meningococcal ACWY vaccine-1 dose after age 16)
Flu Vaccine: Date Administered _____ (must be done yearly)

Hepatitis B Series:(primary series) **AND Hepatitis B Surface Antibody Titer, IgG, Quantitative**

Dates Administered: #1 _____ #2 _____ #3 _____

Hepatitis B Antibody Titer, IgG, Quantitative: Result:

Laboratory report **MUST** be attached. ***If titer proves **NEGATIVE** or **EQUIVOCAL,** a repeat of the Hepatitis B series of 3 vaccines is required.

Booster Dates Administered: #1 _____ #2 _____ #3 _____

MMR Series: (Two shot series with the first dose occurring after the student's 1st birthday, with at least 28 days between doses)
Dates Administered: #1 _____ #2 _____
If you are unable to demonstrate a two-shot series for MMR, then you will need a MMR Antibody Titer, Qualitative: Result: Laboratory report **MUST** be attached.
*If titer proves **NEGATIVE** or **EQUIVOCAL,** then two administrations of the vaccine are required.

Varicella Series: (Two shot series with the first dose occurring after the student's 1st birthday, with at least 28 days between doses)
Dates Administered: #1 _____ #2 _____
If you are unable to demonstrate a two-shot series for Varicella, then you will need a Varicella Antibody Titer, Qualitative: Result: Laboratory report **MUST** be attached.
*If titer proves **NEGATIVE** or **EQUIVOCAL,** then two administrations of the vaccine are required.

Provider initials:_____ Date: _____

Revised: 12/4/23 JC

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Tuberculin Testing

Tuberculosis testing is required within one year prior to UNE start date. Either a TB blood test (QuantiFERON®-TB Gold or T-SPOT® TB) OR a 2-step PPD (TST) are acceptable.

If you check A or B below

An Annual Tuberculosis Symptom Assessment is required http://www.une.edu/studentlife/shc

A- [ ] Prior positive tuberculin skin test

B- [ ] History of latent TB

Record antibiotic therapy, if taken:

Start Date: _____

Date of Completion: _____

Date of chest X-ray (attach report): _____

TB Blood test results- circle results and upload lab report to Medicat

Positive

Negative

Intermediate

Two-Step Tuberculin Skin Test

Step 1

Date Placed: _____

Date Read: _____

mm induration: _____

[ ] negative [ ] consistent with latent TB

Repeat 7 to 21 days after step 1

Step 2

Date Placed: _____

Date Read: _____

mm induration: _____

[ ] negative [ ] consistent with latent TB

Please upload required information to our patient portal:

https://une.medicatconnect.com/

11 Hills Beach Rd
Biddeford, ME 04005
Tel: (207) 602-2358
Fax: (207) 602-5904

716 Stevens Ave.
Portland, ME 04103
Tel: (207) 221-4242
Fax: (207) 523-1913

Health Care Provider Signature/Stamp (REQUIRED):

_____ _____

Signature of Health Care Provider Date

_____ _____

Printed/Typed Name of Health Care Provider Telephone Number

Revised: 12/4/23 JC