ST MARY'S COLLEGE of MARYLAND
The National Public Honors College

Health Services Immunization Form

DUE DATES: August 1st (Fall admission)
December 15th (Spring admission)

Legal Name: _____**Preferred Name**_____ **Pronouns**_____

Date of Birth: ____ /____ /____ **Biologic Sex Assigned at Birth** _____ **Student ID:** _____

SECTION A:
REQUIRED VACCINES

Meningococcal
1-2 doses
Maryland law requires residential students to receive at least one dose of a quadrivalent conjugate meningococcal vaccine at age 16 or older.

Date: ____/ ____/ _____ ☐ Menactra (MenACWY-D) ☐ Menveo (MenACWY-CRM) ☐ MenQuadfi (MenACWY-TT)
Booster: ____/ ____/ _____ ☐ Menactra (MenACWY-D) ☐ Menveo (MenACWY-CRM) ☐ MenQuadfi (MenACWY-TT)

☐ Waiver requested (if checked, you must complete the ***Meningococcal Vaccine Waiver*** form)

Measles/Mumps/Rubella
2 doses

MMR Dose #1: Date ____/____/____ MMR Dose #2: Date ____/ ____/ ____
OR
Measles Dose #1: Date ____/____/____ Measles Dose #2: Date ____/____/____
Mumps Dose #1: Date ____/____/____ Mumps Dose #2: Date ____/____/____
Rubella Dose #1: Date ____/____/____ Rubella Dose #2: Date ____/____/____

Special considerations:
*Students born before 1957 without evidence of immunity should be vaccinated.
*Acceptable evidence of immunity includes documentation of MMR vaccine, laboratory evidence of immunity (blood titer), or history of the disease.
*In a measles outbreak, those born before 1957 without other evidence of immunity should be brought up to date on their MMR vaccination.

Blood titers, as applicable:
Measles lab confirmation of positive immunity: Date____/ ____/ _____
Mumps lab confirmation of positive immunity: Date____/ ____/ _____
Rubella lab confirmation of positive immunity: Date____/ ____/ _____
**If the titers are negative or equivocal, 2 doses of MMR at least 28 days apart are needed. No repeat titer is required after the MMR vaccine series.*

☐ Waiver requested (if checked, you must complete the ***Measles, Mumps, and Rubella Vaccine Waiver*** form)

SECTION B:
RECOMMENDED VACCINES

COVID-19

One dose of an updated COVID-19 vaccine is recommended for everyone, including people who have received a prior COVID-19 vaccine, or have had COVID-19, and people with long COVID.

Date: _____/ _____/ _____ ☐ Moderna ☐ Pfizer-BioNTech ☐ Novavax

Additional dose(s), if applicable:
Date: _____/ _____/ _____ ☐ Moderna ☐ Pfizer-BioNTech ☐ Novavax Date: _____/ _____/ _____ ☐ Moderna ☐ Pfizer ☐ Novavax

Hepatitis A

2 doses
Dose #1: Date _____/ _____/ _____ ☐ Havrix ☐ Vaqta
Dose #2: Date _____/ _____/ _____ ☐ Havrix ☐ Vaqta

Hepatitis B

2-3 dose series

Dose #1: Date _____/ _____/ _____	☐ Heplisav-B	☐ Engerix-B	☐ PreHevbrio	☐ Rebombivax HB
Dose #2: Date _____/ _____/ _____	☐ Heplisav-B	☐ Engerix-B	☐ PreHevbrio	☐ Rebombivax HB
Dose #3: Date _____/ _____/ _____		☐ Engerix-B	☐ PreHevbrio	☐ Rebombivax HB

Hepatitis A and B, Combined *(Twinrix)*

3- 4 dose series
Dose #1: Date _____/ _____/ _____
Dose #2: Date _____/ _____/ _____
Dose #3: Date _____/ _____/ _____
Dose #4: Date _____/ _____/ _____

Human Papillomavirus

2-3 dose series

Dose #1: Date _____/ _____/ _____	☐ Gardasil 9	☐ Gardasil 4	☐ Cervarix
Dose #2: Date _____/ _____/ _____	☐ Gardasil 9	☐ Gardasil 4	☐ Cervarix
Dose #3: Date _____/ _____/ _____	☐ Gardasil 9	☐ Gardasil 4	☐ Cervarix

Influenza

One dose of an updated influenza vaccine annually
Date: _____/ _____/ _____

Meningococcal, Serotype B

☐ Bexsero (MenB-4C) 2-3 dose series **OR** ☐ Trumenba (MenB-FHbp) 2-3 dose series

Dose #1: Date _____/ _____/ _____ Dose #1: Date _____/ _____/ _____
Dose #2: Date _____/ _____/ _____ Dose #2: Date _____/ _____/ _____
Dose #3: Date _____/ _____/ _____ Dose #3: Date _____/ _____/ _____

If administering a pentavalent vaccine, a combination of dosing scenarios is possible depending on intervals between dosing; check off only what applies to this patient:

☐ Penbraya (MenACWY-TT/MenB-FHbp) ☐ Trumenba ☐ any MenACWY vaccine (name:_____)
Dose #1: Date _____/ _____/ _____ Date: _____/ _____/ _____ Date: _____/ _____/ _____
Dose #2: Date _____/ _____/ _____

SECTION B:
RECOMMENDED VACCINES (continued)

MPOX *(Jynneos)*
2 doses
Dose #1: Date _____/ _____/ _____
Dose #2: Date _____/ _____/ _____

Pneumococcal
1-2 doses
Date: _____/ _____/ _____ ☐ Vaxneuvance ☐ Prevnar20 ☐ Capvaxive ☐ Pneumovax23

**If Vaxneuvance was used, it should have been followed by a dose of Pneumovax23 at least 1 year after* Date: _____/ _____/ _____

Polio
Were the primary 4-dose series of inactivated polio vaccine (IPV) completed? ☐ Yes ☐ No
Date of last dose: _____/ _____/ _____

Tetanus/Diphtheria/Pertussis
Were the primary 4-dose series completed? ☐ Yes ☐ No
Date of last booster: _____/ _____/ _____
If tetanus ONLY was received (which is uncommon), date of last booster: _____/ _____/ _____

Varicella
2 doses

Dose #1: Date _____/ _____/ _____ ☐ Varivax ☐ ProQuad (MMR + varicella)
Dose #2: Date _____/ _____/ _____ ☐ Varivax ☐ ProQuad (MMR + varicella)

Special considerations:
Acceptable evidence of immunity can be demonstrated by being born in the U.S. before 1980, having a history of the disease, receiving 2 prior doses of varicella vaccine, or providing documentation of an antibody level consistent with immunity.

Blood titer, as applicable:
Varicella lab confirmation of positive immunity: Date_____/ _____/ _____
**If the titer is negative or equivocal, the varicella series must be repeated with doses at least 4 weeks apart. No titer is required after the varicella vaccine series is complete.*

SECTION C:
REQUIRED TUBERCULOSIS SCREENING

The following questions are to be completed by the students:

1. Have you ever had close contact with people who are known or suspected of having active TB disease?
   ❑ **Yes** ❑ **No**
2. Were you born in one of the countries or territories listed below that have a high incidence of active TB disease? *(If yes, CIRCLE the countries or territories listed in the table on page 4.)*
   ❑ **Yes** ❑ **No**
3. Have you resided in or traveled to one or more of the countries or territories listed above for one to three months or more, in total? *(If yes, CIRCLE the countries or territories listed in the table on page 4.)*
   ❑ **Yes** ❑ **No**

4. Have you been a resident, volunteer, and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)?
   ❑ Yes ❑ No
5. Have you been a volunteer or health care worker who served clients who are at an increased risk for active TB disease?
   ❑ Yes ❑ No
6. Have you ever been a member of any of the following groups that may have an increased incidence of inactive TB infection or active TB disease: *medically underserved, low-income, or using drugs or alcohol*?
   ❑ Yes ❑ No

2025 High-Incidence Country List for TB Disease

Afghanistan	China	Guatemala	Madagascar	Pakistan	Timor-Leste
Algeria	China, *Hong Kong SAR*	Guinea	Malawi	Palau	Togo
Angola	China, *Macao SAR*	Guinea-Bissau	Malaysia	Panama	Tunisia
Anguilla	Colombia	Guyana	Maldives	Papua New Guinea	Turkmenistan
Argentina	Comoros	Haiti	Mali	Paraguay	Tuvalu
Armenia	Congo	Honduras	Marshall Islands	Peru	Uganda
Azerbaijan	Congo *(Democratic Republic of)*	India	Mauritania	Philippines	Ukraine
Bangladesh	Côte d'Ivoire	Indonesia	Mexico	Qatar	Uruguay
Belarus	Djibouti	Iraq	Micronesia (Federal States of)	Romania	Uzbekistan
Belize	Dominican Republic	Kazakhstan	Moldova (Republic of)	Russian Federation	Vanuatu
Benin	Ecuador	Kenya	Mongolia	Rwanda	Venezuela (Bolivarian Republic of)
Bhutan	El Salvador	Kiribati	Morocco	Sao Tome & Principe	Viet Nam
Bolivia *(Plurinational State of)*	Equatorial Guinea	Korea (Democratic People's Republic of)	Mozambique	Senegal	Yemen
Bosnia & Herzegovina	Eritrea	Korea (Democratic Republic of)	Myanmar	Sierra Leone	Zambia
Botswana	Eswatini	Korea (Republic of)	Namibia	Singapore	Zimbabwe
Brazil	Ethiopia	Kyrgyzstan	Nauru	Solomon Islands	
Brunei Darussalam	Fiji	Lao People's Democratic Republic	Nepal	Somalia	
Burkina Faso	Gabon	Lesotho	Nicaragua	South Africa	
Burundi	Gambia	Liberia	Niger	Sri Lanka	
Cabo Verde	Georgia	Libya	Nigeria	Sudan	
Cambodia	Ghana	Lithuania	Niue	Suriname	
Cameroon	Greenland		Northern Mariana Islands	Tajikistan	
Central African Republic	Guam			Tanzania (United Republic of)	
Chad				Thailand	

If you answered YES to any of the above questions, *proceed to page 5*.
St. Mary's College of Maryland requires that you receive TB testing before the start of your first enrolled term.
The significance of any travel exposure should be reviewed with your health care provider.

If you answered NO to all the above questions, no further testing or action is required.

The following test(s) are to be completed by a healthcare provider if the student answered YES to any of the screening questions:

Tuberculosis Skin Test (TST) Date of Test: _____/ _____/ _____ Results: ☐Negative ☐ Positive

OR

Interferon Gamma Release Assay (IGRA):
(QuantiFERON-TB Gold Plus (QFT-Plus) *OR* T-Spot TB)

Date of Test: _____/ _____/ _____ Results: ☐Negative ☐ Positive

Chest X-ray:
(required if current or previous TST or IGRA test is positive)

Date of X-ray: _____/ _____/ _____ Results: ☐ Normal ☐Abnormal

Bacteriologic examinations of sputum specimens, if indicated:
Date of test(s): _____ Results: _____
_____

**TB blood tests (and TB skin tests) should not be performed on people who have written documentation of a previous positive TB test result (TB blood test or TB skin test) or treatment for TB disease. Most people who have a positive TB test result will continue to have a positive test result. Additional TB blood tests will probably not contribute to medical care, regardless of the result.*

I reviewed the information provided on all five (5) pages with the patient and verified that this information is accurate to the best of my knowledge.

Print Provider Name: _____ Provider Signature: _____ Date: _____

Provider Address: _____ Phone: _____

_____

OFFICIAL PROVIDER STAMP:

STUDENT: Once signed by your healthcare provider, upload this form along with the Demographic and Consent form, Health Questionnaire form, and any Vaccination Waiver form(s) into your SMCM Medicat Health Record:

Health Services: New Student Information
www.smcm.edu/health-services/new-student-information

****This is the ONLY immunization record that will be accepted****