St. Mary's College of Maryland
Student Health Services
Immunizations Form for Academic Year 26/27
Fall admission due: August 1 Spring admission due: January 1

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

Date of Birth _____ **Biologic Sex Assigned at Birth** _____ **Student ID** _____

ONLY a signed and stamped form by a medical provider will be accepted; do not upload any other immunization records.
Once completed, upload to the SMCM *Medicat* electronic health record:
Upload forms here in the New Student Information tab

SECTION A:
REQUIRED VACCINES

Meningococcal A, C, W, Y (MenACWY)

1-2 doses (depending on risk factors)
Maryland law requires residential students to receive at least one dose of a quadrivalent conjugate meningococcal vaccine at age 16 or older.

Dose #1: Date ____/____/____
Dose #2: Date ____/____/____

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

Measles/Mumps/Rubella (MMR)

1-3 doses (depending on risk factors)

MMR Dose #1: Date ___/___/___ MMR Dose #2: Date___/___/___ MMR Dose #3: Date___/___/___
-OR-
Measles Dose #1: Date___/___/___ Measles Dose #2: Date___/___/___ Measles Dose #3: Date___/___/___
Mumps Dose #1: Date___/___/___ Mumps Dose #2: Date ___/___/___ Mumps Dose #3: Date ___/___/___
Rubella Dose #1: Date___/___/___ Rubella Dose #2: Date ___/___/___ Rubella Dose #3: 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.
- Blood titers, as applicable: If negative or equivocal, 2 doses of MMR at least 28 days apart are needed. No repeat titer is required once complete.

Measles lab confirmation of positive immunity: Date ____/____/____
Mumps lab confirmation of positive immunity: Date ____/____/____
Rubella lab confirmation of positive immunity: Date ____/____/____

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

SECTION B:
RECOMMENDED VACCINES

COVID-19

1 dose of an updated vaccine
Date:_____/_____/_____

Hepatitis A

2-4 doses (depending on risk factors)
Dose #1: Date_____/_____/_____
Dose #2: Date_____/_____/_____
Dose #3: Date_____/_____/_____
Dose #4: Date_____/_____/_____

Hepatitis B

2-4 doses (depending on risk factors)
Dose #1: Date_____/_____/_____ ☐ Heplisav-B ☐ Engerix-B ☐ PreHevbrio ☐ Rebombivax HB ☐ Twinrix
Dose #2: Date_____/_____/_____ ☐ Heplisav-B ☐ Engerix-B ☐ PreHevbrio ☐ Rebombivax HB ☐ Twinrix
Dose #3: Date_____/_____/_____ ☐ Engerix-B ☐ PreHevbrio ☐ Rebombivax HB ☐ Twinrix
Dose #4: Date_____/_____/_____ ☐Twinrix

Human Papillomavirus (HPV)

2-3 doses (depending on risk factors)
Dose #1: Date_____/_____/_____
Dose #2: Date_____/_____/_____
Dose #3: Date_____/_____/_____

Influenza

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

Meningococcal B (MenB)

2-4 doses (depending on risk factors)
Dose #1: Date_____/_____/_____ ☐ Bexsero ☐ Trumenba
Dose #2: Date_____/_____/_____ ☐ Bexsero ☐ Trumenba
Dose #3: Date_____/_____/_____ ☐ Bexsero ☐ Trumenba
Dose #4: Date_____/_____/_____ ☐ Bexsero ☐ Trumenba

If administering a pentavalent vaccine, a combination of dosing scenarios is possible depending on intervals between dosing; check off only what applies to this student:
☐ MenABCWY
Dose #1: Date_____/_____/_____
Dose #2: Date_____/_____/_____

SECTION B:
RECOMMENDED VACCINES (continued)

MPOX

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

Pneumococcal

Was the primary series of the pneumococcal vaccine completed? ☐ Yes ☐ No
Date of last dose: _____/_____/_____

Polio

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

Tetanus/Diphtheria/Pertussis (Tdap)

Was the primary series of the Tdap series completed? ☐ Yes ☐ No
Date of last booster: _____/_____/_____
If tetanus (Td) ONLY was received (which is uncommon), date of last booster: _____/_____/_____

Varicella (VAR)

2 doses
Dose #1: Date _____/_____/_____
Dose #2: Date _____/_____/_____
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: If the titer is negative or equivocal, the varicella series must be repeated with doses at least 4 weeks apart. No repeat titer is required once complete.

Varicella lab confirmation of positive immunity: Date_____/_____/_____

Print Provider Name _____ **Phone** _____

Address _____

I have verified that this information is accurate to the best of my knowledge.

Provider Signature _____ **Date** _____

This immunization record is informed by:

American Academy of Family Physicians. (n.d.). *Birth through age 18 immunization schedule*.
American Academy of Family Physicians. (n.d.). *Adult immunization schedule*.
American College Health Association. (2025, April). *ACHA immunization recommendations*.

OFFICIAL PROVIDER STAMP: