UNIVERSITY OF MAINE AT AUGUSTA

IMMUNIZATION VERIFICATION FORM

To avoid having your registration access dropped, please complete and upload this form or other acceptable immunization documents to Point and Click as soon as possible. If you have any questions regarding the requested immunization information on this form, please contact UMA at 207/621-3079 or 1-877-UMA-1234 (1-877-862-1234)

TO DE COMDI ETED DV CTUDENT

IANI	1. TO BE COMPLE	TED DI STODENI		
NAME _.	LAST	FIRST	M.I.	
	ESS:			
	STREET/PO BOX	CITY	STATE ZIP	
HOME PHONE:		WORK PHONE:		
DATE OF BIRTH:		MaineStreet ID or last	MaineStreet ID or last 4-digits of SSI#:	
PART		TED AND SIGNED BY A HEAD Thaving the disease is not accepted pro		
A.	TETANUS-DIPHTHER 1. Received tetanus-dip	AIA: phtheria vaccine within the last 10	years/_// Month / Day / Year	
В.	TWO MMR Vaccinations (MEASLES, MUMPS, RUBELLA):			
	1. Received First (1st) 1	MMR dose on	//	
		nd) MMR dose on		
C.	MMR TITER LAB REP	ORTS (if given instead of MMRs	s):	
	1. MEASLES TITER	(Lab Reports Attached)		
	2. MUMPS TITER (L	ab Reports Attached)	/	
	3. RUBELLA TITER	(Lab Reports Attached)	/	

(Complete the back of form, including required signature)

DADT I.

PART III: EXEMPTION (If applicable)

MEDICAL EXEMPTION - TO BE COMPLETED BY A HEALTH CARE PROVIDER Please explain medical exemption in area below. If the exemption is not permanent, please list ending date for exemption. SIGNATURE OF MEDICAL PROFESSIONAL DATE HEALTH CARE PROVIDER: This section must be completed! NAME______SIGNATURE_____ CLINIC NAME ______ ADDRESS_ STREET/PO BOX CITY STATE ZIP CODE PHONE: _____ DATE SIGNED _____

For students: Please upload to point and click through your student portal. For healthcare providers: Please fax completed forms to 207-621-3116 or email to umaar@maine.edu.