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

Immunization Documentation 2023-2024 Academic Year

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 (physician, nurse practitioner, physician's assistant, or registered nurse), or alternative official documentation of their immunization records are acceptable.

*All documentation must include your name and date of birth **and be** signed and legible to be accepted.*
All documentation must be in English.

Forms should be uploaded to the UD Health Portal (https://udhealthportal.udel.edu/) or faxed to 302-831-6407.
Additional information regarding required immunizations, TB screening, meningitis disease and vaccination*, and exemptions can be found on the Student Health website: www.udel.edu/studenthealth/immunization-and-medical-history

Please ensure you have completed your TB screening through your UD Health Portal and if indicated, request a TB blood test from your medical provider for submission to UD.

Section I – To be Completed by Student

Name: _____
Last First Middle

Date of Birth: _____ UDID #: _____

Country of Birth: _____ Date of Arrival in US (if applicable): _____

Section II – To Be Completed by Medical Provider

A. Required Vaccines

Required Vaccines

MMR
Measles, Mumps, Rubella
(Required if born after 1956)
Two doses after age 12 months at least 28 days apart or titers

1. ____/____/____ MM DD YY
2. ____/____/____ MM DD YY

OR

MMR Titers
Lab report must be submitted for results to be accepted

Measles ____/____/____ MM DD YY ☐ Immune ☐ Non-Immune
Mumps ____/____/____ MM DD YY ☐ Immune ☐ Non-Immune
Rubella ____/____/____ MM DD YY ☐ Immune ☐ Non-Immune

Meningococcal ACWY*
Recommended for all students. **Required for 1st year students in on-campus housing.**

1. ☐ Menactra ☐ MenQuadfi ☐ Menveo ☐ Menomune ____/____/____ MM DD YY
2. ☐ Menactra ☐ MenQuadfi ☐ Menveo ☐ Menomune ____/____/____ MM DD YY

**At least one dose must be administered on or after 16 years of age*

B. Required Tuberculosis (TB) Screening

a. Students must complete the online TB screening questionnaire in the "Medical Clearances" section of the UD Health Portal. (https://udhealthportal.udel.edu)
b. *If indicated*, **a TB Blood test within 6 months of enrollment is required,** and results must be submitted to SHS.

TB test type ☐ T-Spot ☐ QuantiFERON **Date:** ___/___/___ MM DD YY **Result:** ☐Negative ☐Positive^ *^Please include documentation of a normal Chest X-ray done in the USA, and documentation of TB/LTBI treatment or refusal of treatment.*

Continued on next page – Medical Provider Signature Required

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UNIVERSITY OF DELAWARE

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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.

Recommended Vaccines

COVID-19 Primary Series	☐ Pfizer ☐ J&J/Janssen ☐ Moderna ☐ Novavax ☐Other: _____ ☐Check if bivalent/single dose mRNA primary vaccine	1. ____/____/____ MM DD YY 2. ____/____/____ MM DD YY *Most Recent COVID-19 Booster* ☐ Pfizer ☐ Moderna ☐ Other: _____ ____/____/____ MM DD YY
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*	____/____/____ 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	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 ☐Tdap ☐Td ____/____/____ MM DD YY
Varicella	1. ____/____/____ MM DD YY 2. ____/____/____ MM DD YY	Varicella Antibody Titer *Must submit lab report* ____/____/____ MM DD YY ☐Immune ☐Non-Immune
Other	Vaccine _____ Date ____/____/____ MM DD YY	Vaccine _____ Date ____/____/____ MM DD YY

D. Completing Medical Provider Information

Name: _____ **Credentials:** _____

Signature: _____ **Date:** _____

Address and Phone Number	

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