NOTRE DAME OF MARYLAND UNIVERSITY

IMMUNIZATION CERTIFICATE

PRINT CLEARLY WITH DARK BLACK INK.
This form will be read by a computer.
Upload to medproctor.com

University: **Notre Dame of Maryland**

Student: DOB:

Green = Required
Blue = Recommended
Black = Optional

MENINGOCOCCAL ACWY Required
1st M M D D Y Y
2nd M M D D Y Y

TDaP - Booster Required
Within 10 yrs. M M D D Y Y

MMR Measles, Mumps, Rubella Required
1st M M D D Y Y
2nd M M D D Y Y

VARICELLA - Chicken Pox Recommended
1st M M D D Y Y
2nd M M D D Y Y

POLIO - Inactivated Recommended
1st M M D D Y Y
2nd M M D D Y Y
3rd M M D D Y Y
4th M M D D Y Y

HEPATITIS A Recommended
1st M M D D Y Y
2nd M M D D Y Y

HEPATITIS B Recommended
1st M M D D Y Y
2nd M M D D Y Y
3rd M M D D Y Y

INFLUENZA Recommended
1st M M D D Y Y

COVID - 19 Recommended
1st M M D D Y Y
2nd M M D D Y Y
3rd M M D D Y Y
Vaccine Manufacturer

REQUIRED - Immunization History Signature (Please clearly complete ALL and place office stamp at bottom of page.)

LICENSED CARE PROFESSIONAL SIGNATURE NON-PARENTAL	PRINT LICENSED HEALTH CARE PROFESSIONAL FIRST AND LAST NAME	SIGNATURE DATE
NPI NUMBER *not required for U.S. service members or international students*	NPI NAME OF LICENSED HEALTH CARE PROFESSIONAL	OFFICE PHONE NUMBER

RECOMMENDED - Tuberculosis Test Results

Tb Skin PPD
Placed: M M D D Y Y
Read: M M D D Y Y
actual induration in MM only m m

mm and range REQUIRED (fill bubble)
- ◯ 0 mm
- ◯ 0 to < 5 mm
- ◯ 5 to < 10 mm
- ◯ 10 to < 15 mm
- ◯ 15 mm or larger

OR

Tb Blood T-Spot QuantiFERON
Test M M D D Y Y

Results
- ◯ Positive
- ◯ Negative

Tuberculosis Test Results Signature (Please clearly complete ALL and place office stamp at bottom of page.)

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REQUIRED - Parent/Guardian Medical Treatment Consent (because you will be under 18 on 10/6/2023 .)

I hereby authorize Notre Dame of Maryland to employ diagnostic procedures and to render any treatment or medical, surgical, psychological or psychiatric care deemed necessary to the health and well-being of my child. I grant permission for the transfer of my child to an accredited hospital or other health care facility if deemed necessary by the medical or mental health provider.

PARENT/GUARDIAN SIGNATURE	PRINT PARENT/GUARDIAN FIRST AND LAST NAME	DATE OF BIRTH	SIGNATURE DATE

OFFICE STAMP