

INSTRUCTIONS

University: **Notre Dame of Maryland**

Student: _____ DOB: _____

✓ HOW TO COMPLETE THESE FORM(S):

- A licensed healthcare professional **MUST** complete and sign **THESE** forms. **ALL green sections are required.**
- PRINT CLEARLY WITH DARK BLACK INK.** A computer will be reading your forms. Fill in circles completely.
- NO** other forms of documentation will be accepted. (Blue Cards, Yellow Cards, State Immunization Records, etc. are NOT accepted)
- Do not fold, cut, or mark on the border lines of these forms.
- Include the Border Lines in your scanned images.
- Review your forms for completeness and accuracy. Double check **ALL** signatures. **MM/DD/YY date formats.**
- Consult your Healthcare Professional before receiving any of the following immunizations.

Your records are due by: First day of class

REQUIRED	RECOMMENDED	OPTIONAL
Required by regulation and /or policy to attend this university.	Recommended for your general well being but NOT required.	Optional information
<p>Documents: Immunization Certificate</p> <p>Immunization Dates: Men A/C/W/Y (1 dose within 5 yrs) TDaP Booster (1 dose within last 10 yrs) Influenza MMR (2 doses OR Pos. Titer) COVID-19</p>	<p>Immunization Dates: Varicella Polio Hepatitis A Hepatitis B Tb Test Results Meningococcal B</p>	<p>Immunization Dates:</p>

✓ UPLOADING YOUR FORMS:

- Review your forms for completeness and accuracy. **Double check ALL signatures.**
- Scan or photograph your documents as JPGs for upload. Be sure to include the border lines and fill the picture frame.
- Upload your completed forms to your account at medproctor.com.
- You may upload your additional documentation for storage and later retrieval. (blue cards, state records, etc.)
- Check your University Email account regularly for messages from MedProctor regarding incomplete information.

You will be notified via email once your information is successfully verified.

BE AWARE:

- * Incomplete/Illegible writing and poor images will be rejected.
- * Completion of these forms by your due date will help expedite your registration process.

Do not upload this page.

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**

Green = Required

Student: _____

DOB: _____

Blue = Recommended

Black = Optional

MMR Measles, Mumps, Rubella Required 1st <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 2nd <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	HEPATITIS B Recommended 1st <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 2nd <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 3rd <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	VARICELLA - Chicken Pox Recommended 1st <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 2nd <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	INFLUENZA Required 1st <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
MENINGOCOCCAL Required 1st <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 2nd <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	COVID - 19 Required 1st <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 2nd <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	HEPATITIS A Recommended 1st <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 2nd <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	COVID - 19 Required 1st <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 2nd <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
COVID - 19 Required 1st <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 2nd <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	TDaP - Booster Required Within 10 yrs. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	POLIO - Inactivated Recommended 1st <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 2nd <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 3rd <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 4th <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	MENINGOCOCCAL B Recommended 1st <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 2nd <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

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

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

RECOMMENDED - Tuberculosis Test Results

Tb Skin PPD Placed: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Read: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> actual induration in MM only <input type="text"/> <input type="text"/>	mm and range REQUIRED (fill bubble) <input type="radio"/> 0 mm <input type="radio"/> 0 to < 5 mm <input type="radio"/> 5 to < 10 mm <input type="radio"/> 10 to < 15 mm <input type="radio"/> 15 mm or larger	OR	Tb Blood T-Spot QuantIFERON Test <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Results <input type="radio"/> Positive <input type="radio"/> Negative
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Tuberculosis Test Results Signature (Please clearly complete ALL and place office stamp at bottom of page.)

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

OFFICE STAMP

