STUDENT LIFE
UNIVERSITY HEALTH SERVICE
UNIVERSITY OF MICHIGAN

Immunization Form for New Students
2018-19

Instructions:

Students who received immunizations in the State of Michigan do *not* need to submit Michigan immunization records, because UHS will have access to them. Please submit all other immunization records.

How to submit immunization records:

1. **Collect records:**

   Gather records from your health care provider(s). Alternatively, you may want to contact your high school or other institutions where immunizations were required.

   AND/OR

   Ask your health care provider to complete page 2 of this form (you complete page 1).

2. **Submit records:**

   Online: Upload records (PDF format) at uhs.umich.edu/immunization-records

   OR

   Mail records including page 1 of this form to:
   University Health Service – HIM Forms
   207 Fletcher St.
   Ann Arbor, MI 48109-1050

Why should I submit my records? Immunization records are used to provide health care to students. Students may also need immunization records for academic programs, volunteer activities and travel.

When should I submit records? Please submit records at least 30 days before classes.

What if I cannot submit records on time? Submit them later, or bring them with you to campus and deliver them when you arrive.

Can I submit records in another language? *Records in English are strongly preferred*, but you can submit records in another language. **Please provide all "Student Information" in English.**

Will I know whether my records were received?

- If you submit online, you will receive confirmation.
- If you mail records, you will *not* receive confirmation.

How can I find out if I received all recommended immunizations? Ask your health care provider to review your record, determine any needs (immunity against many diseases on the form can be determined through tests) and provide recommended immunizations. See recommendations at uhs.umich.edu/immunization-records

I received another immunization after submitting my records. How can I update this information?

1. Photocopy your new immunization record
2. Write your full name and date of birth on it
3. Attach a note saying that it is an update
4. Send it to address in left column of this page

Be sure to keep a copy of all immunization records for yourself!

Student Information (in English):

First name:_____

Last name:_____

Date of birth (month/day/year):_____

University of Michigan ID number: _____

Address:_____

City:_____

State:_____

Country (if not USA):_____

Postal (zip) code:_____

Language of immunization records, if not English:

_____

Sex: ☐ Male ☐ Female ☐ Other

Your health record will be created with the sex (Male or Female) marked here. If Male or Female is not marked, your health record will be created with Unknown sex. The sex listed in your health record can affect health care and insurance billing. If you receive services that will be billed to insurance, the sex marked in your health record needs to match the sex that your health insurance plan has on file in order to avoid claim rejections.

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Student: _____ _____
in English ↑ Last Name ↑ First Name

_____
↑ Birthdate (month/day/year)

Label will be applied here

Immunization history is (check all that apply):

☐ Attached – Include student's name and date of birth in English

☐ Marked below – Only a health care provider should complete section below

Hepatitis A

Dose 1: month_____ day_____ year_____
Dose 2: month_____ day_____ year_____

Hepatitis A+B Combination (TWINRIX)

Dose 1: month_____ day_____ year_____
Dose 2: month_____ day_____ year_____
Dose 3: month_____ day_____ year_____

Hepatitis B

Dose 1: month_____ day_____ year_____
Dose 2: month_____ day_____ year_____
Dose 3: month_____ day_____ year_____
Positive titer: month_____ day_____ year_____

Human Papilloma Virus (HPV)

☐ Gardasil 4 ☐ Gardasil 9 ☐ Cervarix
Dose 1: month_____ day_____ year_____
Dose 2: month_____ day_____ year_____
Dose 3: month_____ day_____ year_____

Meningitis (Meningococcal)

☐ Menactra ☐ Menveo
Dose 1: month_____ day_____ year_____
Dose 2: month_____ day_____ year_____
Dose 3: month_____ day_____ year_____
Dose 4: month_____ day_____ year_____

Meningitis B (Meningococcal)

☐ Bexsero ☐ Trumenba
Dose 1: month_____ day_____ year_____
Dose 2: month_____ day_____ year_____
Dose 3: month_____ day_____ year_____

Measles, Mumps, Rubella (MMR)

Dose 1: month_____ day_____ year_____
Dose 2: month_____ day_____ year_____
Positive titer measles: month_____ day_____ year_____
Positive titer mumps: month_____ day_____ year_____
Positive titer rubella: month_____ day_____ year_____

Polio

Primary series Dose 1: month_____ day_____ year_____
Dose 2: month_____ day_____ year_____
Dose 3: month_____ day_____ year_____
Dose 4: month_____ day_____ year_____
Adult booster: month_____ day_____ year_____

Tetanus-Diphtheria (Pertussis)

Primary series Dose 1: month_____ day_____ year_____
Dose 2: month_____ day_____ year_____
Dose 3: month_____ day_____ year_____
Dose 4: month_____ day_____ year_____
Dose 5: month_____ day_____ year_____
Most recent: ☐ Td ☐ Tdap
month_____ day_____ year_____

Varicella (Chicken Pox)

Dose 1: month_____ day_____ year_____
Dose 2: month_____ day_____ year_____
Had disease: month_____ day_____ year_____
Positive titer: month_____ day_____ year_____

Other including positive titers:

_____ month_____ day_____ year_____
_____ month_____ day_____ year_____

This form was completed by:

_____
↑ Print name of health care provider completing form

_____
↑ Signature Date

_____
↑ Street address

_____
↑ City

_____
↑ State Country (if not USA) Postal (Zip) code