

**SOUTHERN MAINE COMMUNITY COLLEGE
IMMUNIZATION VERIFICATION & WAIVER**

IMPORTANT: This form is NOT to be used by students in the following programs: Cardiovascular Technology, Dietetic Technician, Medical Assisting, Nursing, Paramedicine, Radiography and Respiratory Therapy. Students in these health programs have additional requirements and MUST submit information directly to American Data Bank.

Student Name:	Major:
Date of Birth:	SMCC Student ID: (if known)

RECORD OF IMMUNIZATION

NOTE: Those with a * are immunizations required of ALL students (by Maine law)			
Vaccine	Immunization Schedule	Dates (must include month & year)	Titer-Immune Status (if determined by lab test, indicate status and date of titer)
*Diphtheria/ Tetanus	One dose of TD or DT administered within 10 years of enrollment and every 10 years thereafter.	Last booster:	
*MMR	If combined Measles, Mumps, Rubella vaccine was administered, please record here.	#1 #2	Immune / Not Immune
*Measles (Rubeola)	Two doses of Measles vaccine administered after first birthday. If vaccinated with inactivated Measles vaccine prior to 1968, must be re-immunized.	#1 #2	Date: _____
*Mumps	Two doses of Mumps vaccine administered after first birthday.	#1 #2	Immune / Not Immune
*Rubella	Two doses of Rubella vaccine administered after first birthday.	#1 #2	Immune / Not Immune Date: _____
COVID-19 (required for students living on campus)	Number of doses determined by brand.	#1 #2	Brand of Vaccine _____
Meningococcal (recommended for students living on campus)	Usually 1 dose, but may be 2 doses per physician's direction	#1 #2	
Hepatitis A (recommended for students Culinary Arts)	2 doses, 6 months apart	#1 #2	Immune / Not Immune Date: _____

See reverse for required signatures and immunization waiver information.

**SOUTHERN MAINE COMMUNITY COLLEGE
IMMUNIZATION VERIFICATION & WAIVER**

SIGNATURES & MEDICAL WAIVER (if applicable) SECTIONS

STUDENT SECTION

I understand and agree to the following: 1) in the case of an outbreak of a specific disease for which I am not protected, I may be kept out of College and all College-sponsored activities for the duration of the outbreak; 2) the length of time I may be kept out of the College may vary from a week to over a month depending on the disease and the duration of the outbreak; 3) if I am kept out of the College, the College is not required to provide off-site classes, tutoring or extra-ordinary make-up provisions for work missed in my absence. Absences in excess of any limits established by my instructors (as defined in his or her syllabi) may be upheld; 4) no refunds will be granted to me if I elect to withdraw from a course as a result of missing classes due to an outbreak; and 5) depending on my chosen program of study, (a) the College may not be able to place me in a clinical setting, which would likely prevent me from completing my course within the scheduled time frame; and (b) my medical records will be provided, upon request, to the clinical setting in which I am placed.

I certify that I have read the statement above, and agree to the terms listed in the above statement.

Student Signature

Date

MEDICAL PROVIDER SECTION

Patient Medical Exemption from Immunization (if applicable)

A student is exempt from immunization requirements if the student, or the parent or guardian if the student is a minor, provides a written statement from a physician that immunization against one or more of the diseases may be medically inadvisable. If immunization is not medically advisable for your patient, please explain briefly here (including any end date if the exemption is not permanent):

Signature of Health Care Provider (required)

I certify that the information I have provided on this form is truthful, accurate and complete.

Signature: _____ (Including professional designation, i.e. MD, DO, PA, NP, RN, etc.)	Street: _____
Printed name: _____	City/State/Zip: _____
Date: _____	Phone: _____
	Fax: _____