

**SOUTHERN MAINE COMMUNITY COLLEGE
IMMUNIZATION VERIFICATION & MEDICAL 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:	ID:	Gender: Male ___ Female ___

ALL STUDENTS: Maine state law requires that all Southern Maine Community College students who attend full-time, or who attend less than full-time and are a candidate for a degree or certificate, must provide proof of immunization against measles, mumps, rubella and diphtheria/tetanus. This law does not apply to students enrolled in a distance education program and who do not physically attend any classes or programs at a college campus, center, or site. This law also does not require students born before January 1, 1957, to provide proof of measles, mumps and rubella. Students who are covered by the law MUST have a physician, nurse, or other health care provider complete and sign this form and return this from or present a copy of an Immunization Certificate to the Advising Office **before classes begin**.

WAIVER: To file an exemption to the immunization verification requirement, please complete the back side of this page.

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:	
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	Immune / Not Immune Date: _____
Rubella	Two doses of Rubella vaccine administered after first birthday.	#1 #2	Immune / Not Immune Date: _____
Mumps	Two doses of Mumps vaccine administered after first birthday.	#1 #2	Immune / Not Immune Date: _____
MMR	If combined Measles, Mumps, Rubella vaccine was administered, please record here.	#1 #2	Immune / Not Immune Date: _____

Departmentally Based Immunizations					
Vaccine	Immunization Schedule	Culinary Arts	Residence Halls	Dates (must include month & year)	Titer-Immune Status (if determined by lab test, indicate status and date of titer)
Meningococcal	1 dose, but may be 2 doses per physician's direction		Recommended		
Hepatitis A	2 doses, 6 months apart	Recommended		#1 #2	Immune / Not Immune Date: _____

Information reported on this form is correct to available records which can be made available on request of SMCC.	
Signature: _____ Date: _____	Agency name/professional designation of physician or health care provider: Name: _____ Address: _____ City/State/Zip: _____ Telephone: _____ FAX: _____
Physician/licensed health care provider signature REQUIRED.	

Submit to the Advising Office FAX: 207.741.5760 EMAIL: Advising@smccme.edu

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I am requesting a Medical Waiver for the following immunizations:

All required immunizations

Specific immunizations: MMR Hepatitis B Tetanus/Diphtheria

Other: _____

Note: When requesting a medical waiver, a statement from your health care provider must be provided. Please attach the statement to this document.

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 depending on the disease and the duration of the outbreak; 3) if I am kept out of the College, the Academic Dean will work with me in an attempt to lessen the effect of any prolonged absence, which cannot be guaranteed by the college, 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 the information I have provided on this form is truthful, accurate and complete.

Student

Date