# Immunization Record

***DO NOT SEND THIS FORM UNTIL IT IS COMPLETE. All students must pay a $35.00 processing fee regardless of where immunizations are received. This fee will be posted in the student's bill.***

Please make a copy of this form for your records before returning it to Drexel University.

## Part I – Completed by student (All information must be printed legibly. Please complete the entire section.)

Name _____
Last First Middle Initial

Address _____
Street City State ZIP

Student Identification Number (Required) _____

Date of Entry into Drexel _____ /_____ Date of Birth _____ /_____ /_____
MM YY MM DD YY

Please check: ❑ University Housing ❑ Commuter

❑ Check here if you are a student in the College of Nursing & Health Professions, School of Public Health or Professional Studies in the Health Sciences✶ (Please see additional requirements in sections E, G, and H.)

## Part II – Completed and signed by your healthcare provider

Please give all dates in MM/DD/YY format

**A. MMR (Measles, Mumps, Rubella): Two doses required or individual vaccine as noted below.**

- Dose 1 given at age 12 months or later and Dose 2 after 4 years of age 1. ___/___/___ 2. ___/___/___
  If you do not have two doses of MMR, you must complete 2 doses of B, C, and D.

**B. Measles (Rubeola): Complete all that apply.**

- Immunized with live vaccine at 12 months or later and after age 4 1. ___/___/___ 2. ___/___/___
- Has report of positive immune titer (specify date) 1. ___/___/___
- Had disease confirmed by doctor's records 1. ___/___/___

**C. Rubella (German Measles): Clinical history is not acceptable. Complete all that apply.**

- Immunized with live vaccine at age 12 months or later and after age 4 1. ___/___/___ 2. ___/___/___
- Has report of positive immune titer (specify date) 1. ___/___/___

**D. Mumps: Complete all that apply.**

- Immunized with live vaccine at age 12 months or later and after age 4 1. ___/___/___ 2. ___/___/___
- Has report of positive immune titer (specify date) 1. ___/___/___
- Had disease confirmed by doctor's records 1. ___/___/___

**E. Hepatitis B**

- Completion of at least two of three required (One month is required between dose #1 and dose #2.):
  Dose #1 ___/___/___ Dose #2 ___/___/___ Dose #3 ___/___/___ OR **Hep. B Surface Antigen**
- Hepatitis B surface antigen antibody ___/___/___ ❑ Immune ❑ Not Immune

✶❑ **All CNHP Nursing students must provide documentation of all 3 doses of Hepatitis B AND proof of a positive titer**

**F. Tetanus, Diphtheria, Pertussis (Tdap): Within the past 8–10 years.** One dose of Tdap for all college students, ages 11–64, regardless of interval since last Tdap booster.

- ___/___/___

**G. Tuberculosis (PPD required regardless of prior BCG inoculation)**

- PPD (Mantoux) **Performed in the U.S. within the past 12 months before the start of school**

(Tine or Monovac not acceptable):

_____ mm induration Result: ❑ Negative ❑ Positive Date of test ___/___/___

If greater than 10mm induration, chest X-ray required.

- T Spot (alternative blood test to PPD test) Result: ❑ Normal ❑ Abnormal Date of test ___/___/___
- Chest X-ray result: ❑ Normal ❑ Abnormal Date of X-ray ___/___/___

✶❑ **Additional requirement for College of Nursing and Health Professions students only**:

- Second Step PPD (Mantoux): Must be done 7–9 days after first PPD

_____ mm induration Result: ❑ Negative ❑ Positive Date of test ___/___/___

If greater than 10mm induration, chest X-ray required.

- Chest X-ray Result: ❑ Normal ❑ Abnormal Date of X-ray ___/___/___

**H. Varicella**

Either a history of chicken pox, a positive varicella antibody, or two doses of vaccine given at least one month apart if immunized after age 13 meets the requirement.

- History of disease ❑ Yes ❑ No
- Varicella antibody ___/___/___ ❑ Reactive ❑ Non-reactive
- Immunization: Dose #1 ___/___/___ Dose #2 (if first dose after age 13) ___/___/___

✶❑ **Additional requirement for College of Nursing and Health Professions students only.**
**History of disease does not satisfy the requirement.**

A positive (reactive) Varicella titer or two doses of the vaccine are required.

- Has report of positive immune titer (specify date) ___/___/___ OR
- Immunizaton: Dose #1 ___/___/___ Dose #2 ___/___/___

## Part III – Recommended Vaccine

- Influenza: Annual immunization is recommended to avoid disruption to academic activities.

## Part IV – Physician Information

Name _____

Signature _____

Address _____
Street City State ZIP

Phone Number _____ - _____-_____

## Return Address:

**University City Main Campus**
Health Insurance/Immunization Programs
Drexel University
3210 Chestnut Street, Creese 201
Philadelphia, PA 19104-2875

***Medical or Religious Exemption***

If you require information about medical or religious exemption from the University's immunization and vaccine requirements, please contact the Immunization Office at healthimmu@drexel.edu.