IMMUNIZATION RECORD

Do not send this form until it is complete. A $35 processing fee will be posted to the student's bill regardless of where immunizations are received. Student to complete parts 1 and 3. Physician to complete part 2. PLEASE MAKE A COPY OF THIS FORM FOR YOUR RECORDS.

PART 1: TO BE COMPLETED BY THE STUDENT. ALL INFORMATION MUST BE PRINTED LEGIBLY.		
Last Name:	First Name:	Middle Initial:
Drexel University ID:	DOB:	Date of Entry:
Address:		
Please Check: ___ Commuter ___ University Housing		
Check your college:	University City Campus, Drexel at BCC, or Drexel University Sacramento (all colleges)	College of Nursing and Health Professions College of Medicine School of Public Health

PART 2: TO BE COMPLETED AND SIGNED BY YOUR HEALTHCARE PROVIDER.				
A.	**TUBERCULOSIS** (PPD REQUIRED REGARDLESS OF PRIOR BCG INOCULATION) **Performed in the U.S. within 12 months before the start of school.**			
PPD Tuberculin Skin Test	Date given:	Date read:	Results: _____ mm induration Negative Positive	If positive PPD result: Date of chest X-ray: _____ Result: Normal Abnormal
OR Interferon Gamma Release Assay (IGRA) within two months of matriculation	Date obtained:	T-Spot Quantiferon *(please circle)*	Result: Negative Positive Indeterminate	If positive result: Date of chest X-ray: _____ Result: Normal Abnormal
B.	**TDAP** **Required within last 10 years.**			
Tetanus, Diphtheria, Pertussis (Tdap) No other version is accepted.	Date given:			
C.	**MMR (Measles, Mumps, Rubella)** **Two doses of vaccine, positive titers, or history of disease required.**			
Vaccination 1st dose date:	Vaccination 2nd dose date:			
OR Positive Rubeola (Measles) titer date and results:	**OR** Date of disease (if history):			
OR Positive Mumps titer date and results:	**OR** Date of disease (if history):			
OR Positive Rubella (German Measles) titer date and results:	**OR** Date of disease (if history):			
D.	**VARICELLA (Chicken Pox)** **Complete ONE of the following.**			
History of disease	Yes No			
OR Varicella Antibody	Date:	Reactive Non-reactive		
OR Vaccination 1st dose date:	Vaccination 2nd dose date:			
E.	**HEPATITIS B** **Completion of at least two of three required (one month is required between dose 1 and dose 2).**			
Vaccination 1st dose date:	Vaccination 2nd dose date:	Vaccination 3rd dose date:		
OR Hep B Titer	Date:	Immune Not Immune		

F.	MENINGOCOCCAL Required for students living in University housing.
American College Health Associations Recommendation: A booster dose is now recommended at 16 years of age for those who received the initial dose at age 11–12. If the initial dose was given at 13–15 years, the booster dose should be given at 16–18 years of age. If the initial dose was given at age 16 years or older, no booster is needed, except where there is continuing risk.	
Meningococcal (Menomune OR Menactra) (PA state law for resident students)	Date given:

G.	HEALTHCARE EXAMINER'S STATEMENT
I have verified that the individual I have examined is the named individual on this form and that the above tests/vaccinations were performed in this office/laboratory, or I have reviewed any documentation relative to the student's immunization record.	
Examiner's Name (please print)	
License #:	**Phone:**
Signature of Healthcare Examiner:	**Date:**

PART 3: TO BE SIGNED BY THE STUDENT.

H.	STUDENT STATEMENT Form cannot be processed without student signature.

All Students: The information provided on this form is correct. I understand that failure to complete this form correctly may jeopardize my student standing at Drexel University. I will mail this form to the appropriate address listed below.

Nursing Students: I understand that this form meets University requirements; however, there are additional college requirements that must also be satisfied. I will access them at **www.drexel.edu/cnhp** and forward them to my program.

Student Signature: _____ Date: _____

RETURN ADDRESS:		
University City Campus (includes Drexel at BCC and Drexel University Sacramento)	**College of Nursing and Health Professions, School of Public Health, College of Medicine**	**Medical or Religious Exemptions:** If you require information about medical or religious exemptions from the University's immunization requirements, please contact the Immunization Office at healthimmu@drexel.edu.
Health Insurance/Immunization Programs Drexel University 3210 Chestnut Street, Creese 201 Philadelphia, PA 19104-2875	Office of Student Life New College Building, Suite 1106 245 N. 15th Street, MS 482 Philadelphia, PA 19102	

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