Health Insurance and Immunization Requirements
Drexel Summer Camp Programs
These requirements must be met by June 1, 2014

DREXEL UNIVERSITY
College of
Arts and Sciences
Biodiversity, Earth & Environmental Science

Please send this sheet along with copies of all documentation to:
ATTN: DESLA
BEES Department
Drexel University
3201 Arch St., Ste. 240
Philadelphia, PA 19104

Any student participating in a summer program with a residential component must have the following:

- ☐ Documentation evidencing valid medical insurance ***(Please attach a copy of the front and back of your insurance card)***
- ☐ Documentation of the meningitis vaccination
- ☐ Documentation of a PPD test conducted within the last year
  - If the PPD test is positive, the student must show proof that the chest X-ray is negative.
  - If the PPD test and the chest X-ray are positive, the student will not be permitted to participate in the summer program.

****Any student who cannot meet these requirements by the June 1st deadline will not be able to participate.****

Immunization Record

Part I– Completed by student (all information must be printed legibly)

Last Name _____First Name _____Middle Initial ____
Street Address _____
City _____ State _____ Zip _____
Date of Birth ___/___/___

Part II – Completed by and signed by your health care provider:

(Please give all dates in MM/DD/YY format)

A. Tuberculosis (PPD required regardless of prior BCG inoculation)
- PPD (Mantoux): (Tine or Momovac not acceptable) _____ mm induration
  Result: □ Negative Date of test ___/___/____
  □ Positive

If greater than 10mm induration, chest X-ray required.
- Chest X-ray result: □ Normal Date of X-ray ___/___/____
  □ Abnormal

B. Meningococcal:
- Quadrivalent Polysaccharide Vaccine ___/___/___

Health Care Provider

Name (Please Print): _____ Signature _____
Street Address _____
City, State, Zip _____ Phone Number _____

Allergies and Medications

Part I – Allergies / Chronic Conditions / Dietary Restrictions

A. History of allergies or sensitivity to medicines. □ No □ Yes If yes, please explain:

B. History of allergies or chronic conditions. □ No □ Yes If yes, please explain:

C. Dietary restrictions. □ Vegan □ Vegetarian □ Gluten Intolerant □ Lactose Intolerant □ Other, please explain:

Part II – Medications

A. This student is required to take medication: □ No □ Yes If yes, please complete the following:
The school nurse will determine which medicines the student may keep and which will be stored in the infirmary.

B. **Over-the-counter** medication(s) to be **self-administered by student**:

If yes, Condition	Medication	Dosage	Strength	Directions for Use

C. **Prescription** medication(s) to be **self-administered by student**:

If yes, Condition	Medication	Dosage	Strength	Directions for Use

D. Medications to be **administered by the school nurse**:

If yes, Condition	Medication	Dosage	Strength	Directions for Use

If more space is needed, please attach additional pages.