DREXEL UNIVERSITY
College of
Nursing and
Health Professions

Please review and complete this packet in its entirety. Make a copy for your records.

Please note that all programs may not have the same requirements as other programs due to differences in academic and compliance constraints. These will be indicated with two asterisks (**) on each page.

CNHP IMMUNIZATION RECORD

(7 TOTAL PAGES)

STUDENT INFORMATION		
Last Name:	First Name:	Middle Initial:
Drexel University ID:	DOB:	Date of Entry into Drexel:
Mailing Address:		
Please Check: ☐ University Housing ☐ Commuter	Please Check: ☐ Undergraduate ☐ Graduate	Please Check: ☐ Domestic ☐ International
Program *(check one)*: ☐ ACE ☐ Co-op ☐ CAT ☐ MSN: NP ☐ NS/ISPP ☐ PA ☐ MSN: Advanced Role ☐ HSAD ☐ DNP ☐ COFT ☐ NUAN ☐ PTRS ☐ DPT ☐ Other		

MENINGOCOCCAL FORM

PAGE 1

Meningococcal Quadrivalent:

You only need to complete this section **IF**:

- You are age 21 or younger - you must submit proof that you have received one dose of meningococcal conjugate vaccine (MCV4, such as Menactra or Menveo) since age 16; **OR**
- You will be living in University housing - Pennsylvania Law requires one dose of meningococcal quadrivalent given since age 16.

If neither of the above apply, you do not need to complete this section.

Quadrivalent conjugate *(check one)*: ☐ Menactra ☐ Menveo	Date given:

HEALTH CARE EXAMINER'S STATEMENT	
I have verified that the individual I have examined is the named individual on this page (1) and that the above tests/vaccinations were performed in this office/laboratory or that I have reviewed any documentation relative to the student's immunization record.	
Health Care Examiner's Name (Please Print):	
License #:	**Phone:**
Signature of Health Care Examiner:	**Date:**

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TUBERCULOSIS FORM

STUDENT INFORMATION		
Last Name:	First Name:	Middle Initial:
Drexel University ID:	DOB:	Date of Entry into Drexel:

Program *(check one)*: ☐ACE** ☐Co-op ☐CAT ☐MSN: NP ☐NS/ISPP ☐PA ☐MSN: Advanced Role ☐HSAD ☐DNP ☐COFT ☐NUAN** ☐PTRS ☐DPT ☐Other

Please note that only the blood test is accepted for the NUAN and ACE Programs for **Tuberculosis. Please see option B.

TEST MUST BE PERFORMED IN THE U.S. WITHIN 12 MONTHS OF THE START OF SCHOOL.

Interferon Gamma Release Assay (IGRA)
****THIS IS REQUIRED FOR THE FOLLOWING PROGRAMS: NUAN, ACE, Co-Op, PA, NP, MSN, & DPT PROGRAMS.**

Date Obtained *(Attach results of laboratory test)*:	Please check one: ☐ T-Spot ☐ Quantiferon	Result: ☐ Negative ☐ Positive ☐ Indeterminate	IF POSITIVE RESULT: See Chest X-Ray Information below.

PPD Tuberculin Skin Test (Mantoux 2nd Step must be within 1-3 weeks.) ****THIS IS NOT ACCEPTED FOR THE FOLLOWING PROGRAMS: NUAN, ACE, Co-Op, PA, NP, MSN, & DPT PROGRAMS.**

1st PPD Tuberculin Skin Test *(Must be performed in the United States)*	Date given *(healthcare provider must initial)*:	Date read *(healthcare provider must initial)*:	Result: _____ mm induration ☐ Negative ☐ Positive	IF POSITIVE PPD RESULT: See Chest X-Ray Information below.
2nd PPD Tuberculin Skin Test *(Must be performed in the United States)*	Date given *(healthcare provider must initial)*:	Date read *(healthcare provider must initial)*:	Result: _____ mm induration ☐ Negative ☐ Positive	

TEST MUST BE PERFORMED IN THE U.S. WITHIN 12 MONTHS OF THE START OF SCHOOL.

Chest X-Ray Information: required if tuberculin skin test or IGRA test is positive. *(Copy of X-ray or IGRA must also be attached.)*

Date of Chest X-Ray *(must be done in the United States)*:	Result: ☐ Normal ☐ Abnormal	Date treatment started: *(if abnormal results)*	Date treatment completed: *(if abnormal results)*

HEALTH CARE EXAMINER'S STATEMENT

I have verified that the individual I have examined is the named individual on this page (2) and that the above tests/vaccinations were performed in this office/laboratory or that I have reviewed any documentation relative to the student's immunization record.

Health Care Examiner's Name (Please Print):

License #:	**Phone:**
Signature of Health Care Examiner:	**Date:**

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TDAP FORM

STUDENT INFORMATION		
Last Name:	First Name:	Middle Initial:
Drexel University ID:	DOB:	Date of Entry into Drexel:

Program *(check one)*:
☐ ACE ☐ Co-op ☐ CAT ☐ MSN: NP ☐ NS/ISPP ☐ PA ☐ MSN: Advanced Role
☐ HSAD ☐ DNP ☐ COFT ☐ NUAN ☐ PTRS ☐ DPT ☐ Other

Tdap (Required within last 10 years)	
Tetanus, Diptheria, Pertussis (Tdap) No other version is accepted.	Date given:

HEALTH CARE EXAMINER'S STATEMENT	
I have verified that the individual I have examined is the named individual on this page (3) and that the above tests/vaccinations were performed in this office/laboratory or that I have reviewed any documentation relative to the student's immunization record.	
Health Care Examiner's Name (Please Print):	
License #:	**Phone:**
Signature of Health Care Examiner:	**Date:**

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MMR (Measles, Mumps, Rubella) FORM

STUDENT INFORMATION		
Last Name:	First Name:	Middle Initial:
Drexel University ID:	DOB:	Date of Entry into Drexel:

Program *(check one)*: ☐ACE ☐Co-op ☐CAT ☐MSN: NP ☐NS/ISPP ☐PA ☐MSN: Advanced Role ☐HSAD ☐DNP ☐COFT ☐NUAN ☐PTRS ☐DPT ☐Other

MMR (Measles, Mumps, Rubella)	
Must provide individual titer documentation for each: measles, mumps, and rubella.** ***(Must attach results of laboratory test)	
Vaccination 1st Dose date:	Vaccination 2nd Dose date (minimum of four weeks after 1st Dose date):
Rubeola (Measles) titer results *(Attach results of laboratory test)*:	Date:
Mumps titer results *(Attach results of laboratory test)*:	Date:
Rubella (German Measles) titer results *(Attach results of laboratory test)*:	Date:
Vaccination provided in accordance with **negative** titer results	
Vaccination 1st Dose date:	Vaccination 2nd Dose date (minimum of four weeks after 1st Dose date):

HEALTH CARE EXAMINER'S STATEMENT	
I have verified that the individual I have examined is the named individual on this page (4) and that the above tests/vaccinations were performed in this office/laboratory or that I have reviewed any documentation relative to the student's immunization record.	
Health Care Examiner's Name (Please Print):	
License #:	**Phone:**
Signature of Health Care Examiner:	**Date:**

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VARICELLA (CHICKENPOX) FORM

STUDENT INFORMATION		
Last Name:	First Name:	Middle Initial:
Drexel University ID:	DOB:	Date of Entry into Drexel:

Program *(check one)*: ☐ACE ☐Co-op ☐CAT ☐MSN: NP ☐NS/ISPP ☐PA ☐MSN: Advanced Role ☐HSAD ☐DNP ☐COFT ☐NUAN ☐PTRS ☐DPT ☐Other

Varicella (Chickenpox)		
Completion of two doses of vaccines and titer documentation OR history of the disease and titer documentation are required.** ***(Must Attach results of laboratory test)		
Vaccination 1st Dose date:	Vaccination 2nd Dose date (minimum of four weeks after 1st Dose date):	
History of disease: ☐ Yes ☐ No		
ELISA (EIA) titer required. ***(Attach results of laboratory test)***	Titer date:	Results: ☐ Positive ☐ Negative (must receive two doses if not immune)
Vaccination provided in accordance with **negative** titer results		
Vaccination 1st Dose date:	Vaccination 2nd Dose date (minimum of four weeks after 1st Dose date):	

HEALTH CARE EXAMINER'S STATEMENT	
I have verified that the individual I have examined is the named individual on this page (5) and that the above tests/vaccinations were performed in this office/laboratory or that I have reviewed any documentation relative to the student's immunization record.	
Health Care Examiner's Name (Please Print):	
License #:	**Phone:**
Signature of Health Care Examiner:	**Date:**

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HEPATITIS B FORM

STUDENT INFORMATION		
Last Name:	First Name:	Middle Initial:
Drexel University ID:	DOB:	Date of Entry into Drexel:

Program *(check one)*: ☐ ACE ☐ Co-op ☐ CAT ☐ MSN: NP ☐ NS/ISPP ☐ PA ☐ MSN: Advanced Role ☐ HSAD ☐ DNP ☐ COFT ☐ NUAN ☐ PTRS ☐ DPT ☐ Other

Hepatitis B				
Completion of three doses of vaccines and titer documentation are required.** ***(Must attach results of laboratory test)				
Vaccination 1st Dose date:	Vaccination 2nd Dose date (minimum of four weeks after 1st Dose date):		Vaccination 3rd Dose date (minimum of four months after 2nd Dose date):	
Date titer completed: *(A positive Hepatitis B surface antibody [HepBsAb or antiHepB] is required for Hepatitis B)*			Results: *(Attach results of laboratory test.)* ☐ Positive ☐ Negative (If negative, complete series below)	
Vaccination provided in accordance with **negative** titer results.	1st Dose date:	If first titer is negative, complete Doses 2 and 3.	2nd Dose date:	3rd Dose date:

HEALTH CARE EXAMINER'S STATEMENT	
I have verified that the individual I have examined is the named individual on this page (6) and that the above tests/vaccinations were performed in this office/laboratory or that I have reviewed any documentation relative to the student's immunization record.	
Health Care Examiner's Name (Please Print):	
License #:	**Phone:**
Signature of Health Care Examiner:	**Date:**

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PHYSICAL EXAMINATION AND STUDENT STATEMENT FORM

STUDENT INFORMATION		
Last Name:	First Name:	Middle Initial:
Drexel University ID:	DOB:	Date of Entry into Drexel:

Program *(check one)*: ☐ ACE ☐ Co-op ☐ CAT ☐ MSN: NP ☐ NS/ISPP ☐ PA ☐ MSN: Advanced Role ☐ HSAD ☐ DNP ☐ COFT ☐ NUAN ☐ PTRS ☐ DPT ☐ Other

TO BE COMPLETED BY HEALTH CARE EXAMINER

PHYSICAL EXAMINATION

A physical exam was conducted on the above individual within the past twelve (12) months *(please check one):*	☐ Yes ☐ No	Date of Physical Exam:

I have verified that the individual I have examined is the named individual on this physical examination and immunization form (7 total pages) and that the above tests/vaccinations were performed in this office/laboratory or that I have reviewed any documentation relative to the student's immunization record.

Health Care Examiner's Name (Please Print):

License #:	**Phone:**
Signature of Health Care Examiner:	**Date:**

TO BE COMPLETED BY STUDENT

STUDENT STATEMENT

The information provided on this physical examination and immunization form (7 total pages) is correct. Attached are copies of my required titers.

I understand that failure to complete the form correctly may jeopardize starting in the program.

The following forms have been completed in their entirety and have been/are being submitted:

☐ **Page 1:** Meningococcal Form

☐ **Page 2:** Tuberculosis (TB) Form

☐ **Page 3:** Tdap Form

☐ **Page 4:** MMR (Measles, Mumps, Rubella) Form and Lab Report

☐ **Page 5:** Varicella Form and Lab Report

☐ **Page 6:** Hepatitis B Form and Lab Report

☐ **Page 7:** Physical Examination and Student Statement Form

Student Signature: _____ **Date:** _____