Drexel Student ID #:
Necessary for all students

___ ___ ___ ___ ___ ___ ___ ___

IMMUNIZATION RECORD

Do not upload this form until it is complete. A $35 processing fee will be posted to the student's bill regardless of where immunizations are received.

PART 1: COMPLETED BY THE STUDENT. ALL INFORMATION MUST BE PRINTED LEGIBLY OR FORM CANNOT BE PROCESSED.				
Last Name:	First Name:		Middle Initial:	
DOB:	Date of Entry:			
Full Mailing Address: Street Address	City	State	ZIP Code	
Please Check: ___ University Housing ___ Commuter	Please Check: ___ Undergraduate ___ Graduate	Please Check: ___ Domestic ___ International		
Check your college:	☐ University City Campus or Drexel University Sacramento	☐ 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 OR QUANTIFERON TEST REQUIRED REGARDLESS OF PRIOR BCG INOCULATION) **PPD test performed in the U.S. within 12 months before the start of school** **OR Quantiferon test done in your country with the results in English.**			
PPD Tuberculin Skin Test	Date given:	Date read:	Result: _____ mm induration ☐ Negative ☐ Positive	If positive result: Date of chest X-ray: _____ Result: ☐ Normal ☐ Abnormal
OR Interferon Gamma Release Assay (IGRA) within two months of matriculation. Must include test results in English.	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 OR positive titers if born after 1956.**			
Vaccination 1st dose date:	Vaccination 2nd dose date (minimum of four weeks after dose 1):			
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.**			
Vaccination 1st dose date:	Vaccination 2nd dose date (minimum of four weeks after dose 1):			
OR Varicella Antibody (ELISA) lab report is required	Date:	☐ Reactive ☐ Non-reactive (Must receive two doses if not immune)		
E.	**HEPATITIS B** **Completion of at least two of three required for University compliance (three doses required to complete the series)**			
Vaccination 1st dose date:	Vaccination 2nd dose date (minimum of four weeks after dose 1):	Vaccination 3rd dose date (minimum of four–six months after dose 2):		
OR Hep B Titer	Date:	☐ Immune ☐ Not Immune (If not immune, complete series above)		

F.	MENINGOCOCCAL Required for all full-time undergraduate students under age 21

Meningococcal Quadrivalent:

- All incoming, full-time undergraduate students who are age 21 or younger must submit proof of one dose of meningococcal conjugate vaccine (MCV4, such as Menactra or Menveo) since age 16.
- For any student who will be living in University housing, Pennsylvania law requires one dose of meningococcal Quadrivalent given since the age of 16.

Quadrivalent conjugate (check one): ☐ Menactra ☐ Menveo	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 (MUST BE SIGNED BY STUDENT OR FORM WILL NOT BE PROCESSED)

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 **drexel.edu/cnhp** and forward them to my program.

Student Signature: _____

Drexel Student ID #:

___ ___ ___ ___ ___ ___ ___ ___ ___

RETURN ADDRESS:

University City Campus, Drexel University Sacramento	**College of Nursing and Health Professions, Behavioral Health Counseling, 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.
Please upload your completed forms via the Immunization Form Upload in your DrexelOne Portal. Upload instructions can be found at **drexel.edu/studentaffairs/hii**. If you have any questions, email VaccinesMainCampus@drexel.edu.	Please upload your completed forms via the Immunization Form Upload in your DrexelOne Portal. Upload instructions can be found at **drexel.edu/studentaffairs/hii**. If you have any questions, email VaccinesCNHP@drexel.edu.	

Drexel UNIVERSITY
drexel.edu/undergrad