

IMMUNIZATION FORM

(Please give the dates when the following immunizations were administered. If your physician does not have your records, they can be obtained from your school)

Student's Name _____

1. TETANUS-DIPHTHERIA

- a. Tetanus-Diphtheria booster must be within the last ten years _____ (month / year)

2. M.M.R. (Measles, Mumps, Rubella)

- a. Two doses required or individual vaccine as noted below.

1. Dose 1 given at 12 months after birth or later and Dose 2 after 1980

(1) _____ (month / year) (2) _____ (month / year)

3. MEASLES (Rubeola) – check all that apply.

- a. Immunized with live measles vaccine at 12 months after birth or later and after 1980

_____ (month / year)

- b. Has report of positive immune titer. Specify date, attach report _____ (month / year)

- c. Had disease confirmed by doctor's records _____ (month / year)

4. RUBELLA (German Measles) – Clinical History is not acceptable. Check all that apply.

- a. Immunized with live measles vaccine at 12 months after birth or later and after 1980

_____ (month / year)

- b. Has report of positive immune titer. Specify date, attach report _____ (month / year)

5. MUMPS – check all that apply.

- a. Immunized with live measles vaccine at 12 months after birth or later and after 1980

_____ (month / year)

- b. Has report of positive immune titer. Specify date, attach report _____ (month / year)

- c. Had disease confirmed by doctor's records _____ (month / year)

6. TUBERCULOSIS – PPD required regardless of prior BCG inoculation.

- a. PPD (mantoux) within the past 12 months (tine or momovac not acceptable)

_____ (month / year)

- b. Result: Neg ___ Pos ___ mm induration (Horizontal diameter) _____ (month / year)

- c. If greater than 5 mm induration, chest X-ray required, result:

Normal _____ Abnormal _____

- d. Received BCG: Yes ___ No ___ If yes _____ (month / year)

7. POLIO

- a. Completed primary series of polio immunization:

b. _____ (month / year)

- c. Result: Neg ___ Pos ___ mm induration (Horizontal diameter) _____ (month / year)

- d. If greater than 5 mm induration, chest X-ray required, result:

Normal _____ Abnormal _____

- e. Received BCG: Yes ___ No ___ If yes _____ (month / year)

8. HEPATITIS B

- a. Completion of at least 2 or three required doses:

Dose #1 _____ (month / year) Dose #2 _____ (month / year) Dose #3 _____ (month / year)

- b. Hepatitis B surface antigen antibody _____ (month / year) reactive _____ (month / year)

9. VARICELLA (Chicken Pox)

- a. History of Disease Yes ___ No ___ Vaccinated _____ (month / year)

10. MENINGITIS VACCINE - PA law requires vaccine or a signed waiver for all students living in residence.

Please check one.

- a. Vaccine received _____ (month / year)

- b. Will sign waiver at registration into residence hall.