



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

CLINICAL 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: <input type="checkbox"/> University Housing <input type="checkbox"/> Commuter	Please Check: <input type="checkbox"/> Undergraduate <input type="checkbox"/> Graduate	Please Check: <input type="checkbox"/> Domestic <input type="checkbox"/> International

MENINGOCOCCAL FORM		PAGE 1
Meningococcal Quadrivalent:		
You only need to complete this section IF :		
<ul style="list-style-type: none"> 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; OR You are a Physician Assistant student in the Salus at Drexel University PA Program. 		
If none of the above apply, you do not need to complete this section.		
Quadrivalent conjugate (check one): <input type="checkbox"/> Menactra <input type="checkbox"/> 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:



TUBERCULOSIS FORM

STUDENT INFORMATION

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

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

Interferon Gamma Release Assay (IGRA)

Date Obtained <i>(Attach results of laboratory test):</i>	Please check one: <input type="checkbox"/> T-Spot <input type="checkbox"/> Quantiferon	Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate	IF POSITIVE RESULT: See Chest X-Ray Information below.
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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 <i>(must be done in the United States):</i>	Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Date treatment started: <i>(if abnormal results)</i>	Date treatment completed: <i>(if abnormal results)</i>
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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:



TDAP FORM

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STUDENT INFORMATION

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

Tdap (Required within last 10 years)

Tetanus, Diphtheria, Pertussis (Tdap) No other version is accepted.	Date given:
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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:



MMR (Measles, Mumps, Rubella) FORM

STUDENT INFORMATION

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

MMR (Measles, Mumps, Rubella)

***Must provide individual titer documentation for each: measles, mumps, and rubella.
(Must attach results of laboratory test)**

Vaccination 1 st Dose date:	Vaccination 2 nd Dose date (minimum 4 weeks after 1st dose date)
Rubeola (Measles) titer results <i>(Attach results of laboratory test):</i>	Date:
Mumps titer results <i>(Attach results of laboratory test):</i>	Date:
Rubella (German Measles) titer results <i>(Attach results of laboratory test):</i>	Date:
Vaccination provided in accordance with negative titer results	
Vaccination 1 st Dose date:	Vaccination 2 nd Dose date (minimum of four weeks after 1 st 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:



VARICELLA (CHICKENPOX) FORM

STUDENT INFORMATION

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

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 1 st Dose date:	Vaccination 2 nd Dose date (minimum of four weeks after 1 st Dose date):	
History of disease: <input type="checkbox"/> Yes <input type="checkbox"/> No		
ELISA (EIA) titer required. (Attach results of laboratory test)	Titer date:	Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative (must receive two doses if not immune)
Vaccination provided in accordance with negative titer results		
Vaccination 1 st Dose date:	Vaccination 2 nd Dose date (minimum of four weeks after 1 st 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:



HEPATITIS B FORM

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STUDENT INFORMATION

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

Hepatitis B

***Completion of three doses of vaccines and titer documentation are required.
(Must attach results of laboratory test)**

Vaccination 1 st Dose date:	Vaccination 2 nd Dose date (minimum of four weeks after 1 st Dose date):	Vaccination 3 rd Dose date (minimum of four months after 2 nd Dose date):
Date titer completed: <i>(A positive Hepatitis B surface antibody [HepBsAb or antiHepB] is required for Hepatitis B)</i>		Results: <i>(Attach results of laboratory test.)</i> <input type="checkbox"/> Positive <input type="checkbox"/> Negative (If negative, complete series below)
Vaccination provided in accordance with negative titer results.	1 st Dose date: If first titer is negative, complete Doses 2 and 3.	2 nd Dose date: 3 rd 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:



PHYSICAL EXAMINATION AND STUDENT STATEMENT FORM

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STUDENT INFORMATION

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

TO BE COMPLETED BY HEALTH CARE EXAMINER

PHYSICAL EXAMINATION

A physical exam was conducted on the above individual within the past twelve (12) months <i>(please check one):</i> 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: