Pennsylvania Academy of the Fine Arts PAFA

IMMUNIZATION RECORD

THIS FORM IS MANDATORY FOR STUDENTS WHO PLAN TO LIVE IN STILES HALL. Follow the instructions very carefully. Failure to submit a form or incomplete forms (e.g., failure to attach the required immunization record for a student certification) may result in not being admitted to student housing.

Part 1: Completed by the Student

Student Name:	Date of Birth (mm/dd/yyyy):
Mailing Address:	

Part 2: Completed by 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/T-Spot performed in your country with the results in English.**			
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 result: Date of chest X-ray (must be done in the U.S.):_____ Result: ☐ Normal ☐ Abnormal
OR Interferon Gamma Release Assay (IGRA) within two months of matriculation. **Must include test results in English**	Date Obtained:	Please Circle: **T-Spot** **Quantiferon**	Result: ☐ Negative ☐ Positive ☐ Indeterminate	If positive result: Date of check x-ray (must be done in the U.S.):_____ 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 blood test showing immunity if born after 1956.** **Lab results required**
Vaccination 1st dose date:	Vaccination 2nd dose date (minimum of four weeks after dose 1):
OR Positive Rubeola (Measles) titer date and results:	
OR Positive Mumps titer date and results:	
OR Positive Rubella (German Measles) titer date and results:	

D.	**Varicella (Chicken Pox)** **Complete ONE of the following: history of disease, two doses of vaccine, or blood test showing immunity.**	
History of disease: ___Yes ___No OR Vaccination 1st dose date:		Vaccination 2nd dose date (minimum of four weeks after dose 1):
OR Varicella Antibody (ELISA) **Lab repost 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 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 eight weeks after dose 2 and a minimum of 16 weeks after dose 1):
OR Hep B Titer **Lab repost is required.**	Date:	□ Immune	

F.	**Meningococcal**
Meningococcal Quadrivalent: • For any student who will be living in student 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: Signed by the Student and/or Parent or Guardian (if student is under 18)

I certify that the information provided on this form is correct. I understand that failure to complete this form correctly may jeopardize my enrollment in student housing at PAFA.

Student Signature_____ Date_____

If under 18:

Parent or Guardian Signature_____ Date_____

Mail this form with records attached to the address below:
PAFA
Student Services
Attn: Katherine Volpe
128 N Broad St, 3rd Floor
Philadelphia. PA 19102

For questions or medical or religious exemptions, please contact Katherine Volpe at kvolpe@pafa.edu