

# 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

<b>A.</b>	<b>Tuberculosis (PPD or Quantiferon test required regardless of prior BCG inoculation)</b> <b>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.</b>			
PPD Tuberculin Skin Test  <b>Must be performed in the United States</b>	Date given (healthcare provider must initial):	Date read (healthcare provider must initial):	Result: _____ mm induration <input type="checkbox"/> Negative <input type="checkbox"/> Positive	If positive result: Date of chest X-ray (must be done in the U.S.): _____ Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
OR Interferon Gamma Release Assay (IGRA) within two months of matriculation.  <b>Must include test results in English</b>	Date Obtained:	Please Circle:  <b>T-Spot</b>  <b>Quantiferon</b>	Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate	If positive result: Date of check x-ray (must be done in the U.S.): _____ Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal

  

<b>B.</b>	<b>TDAP</b> <b>Required within last 10 years</b>	
Tetanus, Diphtheria, Pertussis (TDAP)  No other version is accepted	Date given:	

  

<b>C.</b>	<b>MMR (Measles, Mumps, Rubella)</b> <b>Two doses of vaccine OR blood test showing immunity if born after 1956.</b> <b>Lab results required</b>	
Vaccination 1 <sup>st</sup> dose date:		Vaccination 2 <sup>nd</sup> 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:		

  

<b>D.</b>	<b>Varicella (Chicken Pox)</b> <b>Complete ONE of the following: history of disease, two doses of vaccine, or blood test showing immunity.</b>	
History of disease: ___ Yes ___ No OR Vaccination 1 <sup>st</sup> dose date:		Vaccination 2 <sup>nd</sup> dose date (minimum of four weeks after dose 1):
OR Varicella Antibody (ELISA)  <b>Lab repost is required.</b>	Date:	<input type="checkbox"/> Reactive <input type="checkbox"/> Non-reactive (Must receive two doses if not immune)

<b>E.</b>	<b>Hepatitis B</b> <b>Completion of at least two of three required for compliance (three doses required to complete the series)</b>		
Vaccination 1 <sup>st</sup> dose date:		Vaccination 2 <sup>nd</sup> dose date (minimum of four weeks after dose 1):	Vaccination 3 <sup>rd</sup> dose date (minimum of eight weeks after dose 2 and a minimum of 16 weeks after dose 1):
OR Hep B Titer  <b>Lab repost is required.</b>	Date:	<input type="checkbox"/> Immune	

<b>F.</b>	<b>Meningococcal</b>		
<b>Meningococcal Quadrivalent:</b> <ul style="list-style-type: none"> <li>For any student who will be living in student housing, Pennsylvania law requires one dose of meningococcal Quadrivalent given since the age of 16.</li> </ul>			
<b>Quadrivalent conjugate (check one):</b> <input type="checkbox"/> Menactra <input type="checkbox"/> Menveo		Date given:	

<b>G.</b>	<b>Healthcare Examiner's Statement</b>		
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.			
<b>Examiner's Name (please print):</b>			
<b>License #:</b>			<b>Phone:</b>
<b>Signature of Healthcare Examiner:</b>			<b>Date:</b>

### 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: Elizabeth Ajagbe**  
**128 N Broad St, 3<sup>rd</sup> Floor**  
**Philadelphia. PA 19102**

*For questions or medical or religious exemptions, please contact Elizabeth Ajagbe at [eajagbe@pafa.edu](mailto:eajagbe@pafa.edu).*