

**University of Pennsylvania
Perelman School of Medicine**

Visiting Student Application for Clinical Electives

Immunization Record

APPLICANT NAME: Last

First

Birthdate

The Perelman School of Medicine at the University of Pennsylvania requires that all visiting students meet all of the immunization requirements listed below. All applicants must submit this completed immunization form in order to be considered for an experience at Penn. This form must be completed, signed and dated by a health care provider. Applicants should be free from symptoms of infectious disease upon their arrival.

MEASLES, MUMPS, RUBELLA (MMR) Requirement: 2 doses of MMR vaccine are required. Dose 1 must be administered after the 1st birthday.

Dose 2 must be administered at least 4 weeks after the 1st dose. Or submission of a blood test showing immunity if documentation of two dose completed series is unavailable.

MMR Dose 1 _____ Dose 2 _____ **OR**

MEASLES Dose 1 _____ Dose 2 _____ OR Blood Test: Positive Quantitative Result: _____ Date _____ Infection Date _____

MUMPS Dose 1 _____ Dose 2 _____ OR Blood Test: Positive Quantitative Result: _____ Date _____ Infection Date _____ Positive

RUBELLA Dose 1 _____ Dose 2 _____ OR Blood Test: Quantitative Result: _____ Date _____

HEPATITIS B: 3 doses of Hepatitis B vaccine and a positive titer are required. Doses 1 and 2 must be administered at least 4 weeks apart. Dose 3 should be at least 6 months after the 1st dose and 8 weeks after the 2nd dose. The titer must be at least 4 weeks after the 3rd dose of Hep B vaccine. **Select 1 of 3 below:**

1) Three shot series plus positive titer

Dose 1 _____ Dose 2 _____ Dose 3 _____ Hep B Surface Antibody: **Positive** Quantitative Result: _____ Date _____

2) Three shot series with negative titer. Repeat Hep B vaccine (Dose 4) then repeat titer in 4 weeks. If the titer is positive, no further action needed. If the titer is negative, then continue with 2 more vaccines (doses 5 & 6) in the repeat series and recheck titer 4 weeks after final vaccine dose 6.

Dose 1 _____ Dose 2 _____ Dose 3 _____ Hep B Surface Antibody: **Negative** Quantitative Result: _____ Date _____

Dose 4 _____ Dose 5 _____ Dose 6 _____ Hep B Surface Antibody: **Positive** Quantitative Result: _____ Date _____

3) Non-Responders – Three shot series completed twice with two negative titers- Then a Hepatitis B Surface Antigen Titer is needed

Dose 1 _____ Dose 2 _____ Dose 3 _____ Hep B Surface Antibody: **Negative** Quantitative Result: _____ Date _____

Dose 4 _____ Dose 5 _____ Dose 6 _____ Hep B Surface Antibody: **Negative** Quantitative Result: _____ Date _____

Hepatitis B Surface Antigen **Negative** Date _____ **Positive** Date _____
If positive needs Physician evaluation – must provide documentation

VARICELLA: 2 doses of varicella (chicken pox) vaccine are required. They must be administered at least 4 weeks apart. Or submission of a blood test showing immunity if documentation of two dose completed series is unavailable.

Dose 1 _____ Dose 2 _____ **OR** Blood Test: Positive Quantitative Result _____ Date: _____

TUBERCULOSIS: Results of last (2) PPD's OR (1) IGRA blood test are required. Any student with a positive reaction must forward the results of the evaluation, including results of a chest x-ray and subsequent management, along with this application. (2) PPD results within 12 months of each other with the most recent one within 6 months of the requested elective date. OR (1) IGRA result should be within the past 6 months.

Date of last PPD test _____ Negative Positive **If positive, chest x-ray/disease management report required**

Date of previous PPD test _____ Negative Positive **If positive, chest x-ray/disease management report required**

OR

IGRA (Interferon Gamma Release Assay) Blood test for TB infection.

Negative Positive Other (specify) _____; Date _____ **If positive, chest x-ray/disease management report required**

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MENINGOCOCCAL: One dose of Meningococcal vaccine is required if living in campus housing. Students may satisfy this requirement either through immunization or by submitting the Meningococcal Waiver form found at <https://upenn.app.box.com/s/qmvcwy8w84i01rcwjc8mpl46y7n0grcg>

Dose 1 _____

TETANUS-DIPHTHERIA AND PERTUSSIS (Tdap): (1) dose of adult Tdap. If last Tdap is more than 10 years old Td or Tdap vaccine booster is also required.

Tdap: Dose 1 _____ Td or Tdap Vaccine booster (if more than 10 years since last Tdap) Date _____

INFLUENZA: (1) dose required each year. Due no later than December 1st

Seasonal Flu Vaccine Date _____

COVID-19: Proof of vaccination, dosage depending upon vaccine.

Pfizer Moderna Other: _____

Dose 1 _____ Dose 2 _____ Dose 3 _____

Health Care Provider

Print Name _____ Phone # _____

Signature _____ Date _____

Address _____