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.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Dose 1</th>
<th>Dose 2</th>
<th>Dose 3</th>
<th>Dose 4</th>
<th>Dose 5</th>
<th>Dose 6</th>
<th>Blood Test:</th>
<th>Positive Quantitative Result:</th>
<th>Date</th>
<th>Infection Date</th>
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<td>MMR</td>
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<td>OR</td>
<td>Positive Quantitative Result:</td>
<td>Date</td>
<td>Infection Date</td>
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<td>MEASLES</td>
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<td>Positive</td>
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<td>MUMPS</td>
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<td>RUBELLA</td>
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<td>Positive</td>
<td>Quantitative Result:</td>
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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 ______
   Hepatitis B Surface Antigen: Negative
   Date
   Positive
   Date

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 ______
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
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 http://www.vpul.upenn.edu/shs/files/meningwaiver2011.pdf
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: (2) dose depending upon vaccine
☐ Pfizer ☐ Moderna ☐ Johnson & Johnson
Dose 1 ____________ Dose 2 ____________ Dose 1 ____________

Health Care Provider

Print Name ___________________________________ Phone # ___________________________________
Signature ___________________________________ Date ________________________________
Address ___________________________________