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>MMR Dose 1</th>
<th>Dose 2</th>
<th>OR</th>
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**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 □

**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

Dose 1__________ Dose 2__________ Dose 3__________

Health Care Provider

Print Name________________________ Phone #________________________

Signature__________________________ Date________________________

Address_______________________________