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 ________

RUBELLA Dose 1_______ Dose 2_______ *OR* Blood Test: ☐ Positive Quantitative Result: __________ Date ____________

HEPATITIS B: 3 doses of Hepatitis B vaccine 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. Or submission of a blood test showing immunity if documentation of the completed series of three doses is unavailable. 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. Repeated three shot series with positive titer

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

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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 12 months of the requested elective date. OR (1) IGRA result should not expire during proposed elective rotation dates.

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 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 vaccine booster is also required.

Tdap**:** Dose 1 _______________ Td Vaccine booster (if more than 10 years since last Tdap) Date_______________

INFLUENZA: (1) dose annual each fall required for rotations from October 22nd – March 23rd

Seasonal Flu Vaccine Date ________________

Health Care Provider

Print Name____ **Phone #**______________________________

Signature____ **Date**_________________________________

Address____