DREXEL UNIVERSITY
College of Nursing and Health Professions

Please review and complete this packet in its entirety. Make a copy for your records.

CNHP IMMUNIZATION RECORD

(7 TOTAL PAGES)

STUDENT INFORMATION		
Last Name:	First Name:	Middle Initial:
Drexel University ID:	DOB:	Date of Entry into Drexel:
Mailing Address:		
Please Check: ☐ University Housing ☐ Commuter	Please Check: ☐ Undergraduate ☐ Graduate	Please Check: ☐ Domestic ☐ International
Program *(check one)*: ☐ ACE ☐ Co-op ☐ CAT ☐ MSN: NP ☐ NS/ISPP ☐ PA ☐ MSN: Advanced Role ☐ HSAD ☐ DNP ☐ COFT ☐ NUAN ☐ PTRS ☐ DPT ☐ Other		

MENINGOCOCCAL FORM

Meningococcal Quadrivalent:

You only need to complete this section **IF**:

- You are age 21 or younger - you must submit proof that you have received one dose of meningococcal conjugate vaccine (MCV4, such as Menactra or Menveo) since age 16; **OR**
- You will be living in University housing - Pennsylvania Law requires one dose of meningococcal quadrivalent given since age 16.

If neither of the above apply, you do not need to complete this section.

Quadrivalent conjugate *(check one)*: ☐ Menactra ☐ Menveo	Date given:

HEALTH CARE EXAMINER'S STATEMENT	
I have verified that the individual I have examined is the named individual on this page (1) and that the above tests/vaccinations were performed in this office/laboratory or that I have reviewed any documentation relative to the student's immunization record.	
Health Care Examiner's Name (Please Print):	
License #:	**Phone:**
Signature of Health Care Examiner:	**Date:**

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TUBERCULOSIS FORM

STUDENT INFORMATION		
Last Name:	First Name:	Middle Initial:
Drexel University ID:	DOB:	Date of Entry into Drexel:

Program *(check one)*: ☐ ACE ☐ Co-op ☐ CAT ☐ MSN: NP ☐ NS/ISPP ☐ PA ☐ MSN: Advanced Role ☐ HSAD ☐ DNP ☐ COFT ☐ NUAN** ☐ PTRS ☐ DPT ☐ Other

TEST MUST BE PERFORMED IN THE U.S. WITHIN 12 MONTHS OF THE START OF SCHOOL

Interferon Gamma Release Assay (IGRA)

Date Obtained *(Attach results of laboratory test)*:	Please check one: ☐ T-Spot ☐ Quantiferon	Result: ☐ Negative ☐ Positive ☐ Indeterminate	IF POSITIVE RESULT: See Chest X-Ray Information below.

TEST MUST BE PERFORMED IN THE U.S. WITHIN 12 MONTHS OF THE START OF SCHOOL.

Chest X-Ray Information: required if tuberculin skin test or IGRA test is positive. *(Copy of X-ray or IGRA must also be attached.)*

Date of Chest X-Ray *(must be done in the United States)*:	Result: ☐ Normal ☐ Abnormal	Date treatment started: *(if abnormal results)*	Date treatment completed: *(if abnormal results)*

HEALTH CARE EXAMINER'S STATEMENT

I have verified that the individual I have examined is the named individual on this page (2) and that the above tests/vaccinations were performed in this office/laboratory or that I have reviewed any documentation relative to the student's immunization record.

Health Care Examiner's Name (Please Print):

License #:	**Phone:**
Signature of Health Care Examiner:	**Date:**

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TDAP FORM

STUDENT INFORMATION		
Last Name:	First Name:	Middle Initial:
Drexel University ID:	DOB:	Date of Entry into Drexel:
Program *(check one)*: ☐ ACE ☐ Co-op ☐ CAT ☐ MSN: NP ☐ NS/ISPP ☐ PA ☐ MSN: Advanced Role ☐ HSAD ☐ DNP ☐ COFT ☐ NUAN ☐ PTRS ☐ DPT ☐ Other		

Tdap (Required within last 10 years)	
Tetanus, Diptheria, Pertussis (Tdap) No other version is accepted.	Date given:

HEALTH CARE EXAMINER'S STATEMENT	
I have verified that the individual I have examined is the named individual on this page (3) and that the above tests/vaccinations were performed in this office/laboratory or that I have reviewed any documentation relative to the student's immunization record.	
Health Care Examiner's Name (Please Print):	
License #:	**Phone:**
Signature of Health Care Examiner:	**Date:**

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MMR (Measles, Mumps, Rubella) FORM

STUDENT INFORMATION		
Last Name:	First Name:	Middle Initial:
Drexel University ID:	DOB:	Date of Entry into Drexel:

Program *(check one)*: ☐ ACE ☐ Co-op ☐ CAT ☐ MSN: NP ☐ NS/ISPP ☐ PA ☐ MSN: Advanced Role ☐ HSAD ☐ DNP ☐ COFT ☐ NUAN ☐ PTRS ☐ DPT ☐ Other

MMR (Measles, Mumps, Rubella)	
Must provide individual titer documentation for each: measles, mumps, and rubella.** ***(Must attach results of laboratory test)	
Vaccination 1st Dose date:	Vaccination 2nd Dose date (minimum of four weeks after 1st Dose date):
Rubeola (Measles) titer results *(Attach results of laboratory test)*:	Date:
Mumps titer results *(Attach results of laboratory test)*:	Date:
Rubella (German Measles) titer results *(Attach results of laboratory test)*:	Date:
Vaccination provided in accordance with **negative** titer results	
Vaccination 1st Dose date:	Vaccination 2nd Dose date (minimum of four weeks after 1st Dose date):

HEALTH CARE EXAMINER'S STATEMENT	
I have verified that the individual I have examined is the named individual on this page (4) and that the above tests/vaccinations were performed in this office/laboratory or that I have reviewed any documentation relative to the student's immunization record.	
Health Care Examiner's Name (Please Print):	
License #:	**Phone:**
Signature of Health Care Examiner:	**Date:**

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VARICELLA (CHICKENPOX) FORM

STUDENT INFORMATION		
Last Name:	First Name:	Middle Initial:
Drexel University ID:	DOB:	Date of Entry into Drexel:
Program *(check one)*: ☐ ACE ☐ Co-op ☐ CAT ☐ MSN: NP ☐ NS/ISPP ☐ PA ☐ MSN: Advanced Role ☐ HSAD ☐ DNP ☐ COFT ☐ NUAN ☐ PTRS ☐ DPT ☐ Other		

Varicella (Chickenpox)		
Completion of two doses of vaccines and titer documentation OR history of the disease and titer documentation are required.** ***(Must Attach results of laboratory test)		
Vaccination 1st Dose date:	Vaccination 2nd Dose date (minimum of four weeks after 1st Dose date):	
History of disease: ☐ Yes ☐ No		
ELISA (EIA) titer required. ***(Attach results of laboratory test)***	Titer date:	Results: ☐ Positive ☐ Negative (must receive two doses if not immune)
Vaccination provided in accordance with **negative** titer results		
Vaccination 1st Dose date:	Vaccination 2nd Dose date (minimum of four weeks after 1st Dose date):	

HEALTH CARE EXAMINER'S STATEMENT	
I have verified that the individual I have examined is the named individual on this page (5) and that the above tests/vaccinations were performed in this office/laboratory or that I have reviewed any documentation relative to the student's immunization record.	
Health Care Examiner's Name (Please Print):	
License #:	**Phone:**
Signature of Health Care Examiner:	**Date:**

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HEPATITIS B FORM

STUDENT INFORMATION		
Last Name:	First Name:	Middle Initial:
Drexel University ID:	DOB:	Date of Entry into Drexel:

Program *(check one)*: ☐ ACE ☐ Co-op ☐ CAT ☐ MSN: NP ☐ NS/ISPP ☐ PA ☐ MSN: Advanced Role ☐ HSAD ☐ DNP ☐ COFT ☐ NUAN ☐ PTRS ☐ DPT ☐ Other

Hepatitis B				
Completion of three doses of vaccines and titer documentation are required.** ***(Must attach results of laboratory test)				
Vaccination 1st Dose date:	Vaccination 2nd Dose date (minimum of four weeks after 1st Dose date):		Vaccination 3rd Dose date (minimum of four months after 2nd Dose date):	
Date titer completed: *(A positive Hepatitis B surface antibody [HepBsAb or antiHepB] is required for Hepatitis B)*			Results: *(Attach results of laboratory test.)* ☐ Positive ☐ Negative (If negative, complete series below)	
Vaccination provided in accordance with **negative** titer results.	1st Dose date:	If first titer is negative, complete Doses 2 and 3.	2nd Dose date:	3rd Dose date:

HEALTH CARE EXAMINER'S STATEMENT	
I have verified that the individual I have examined is the named individual on this page (6) and that the above tests/vaccinations were performed in this office/laboratory or that I have reviewed any documentation relative to the student's immunization record.	
Health Care Examiner's Name (Please Print):	
License #:	**Phone:**
Signature of Health Care Examiner:	**Date:**

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PHYSICAL EXAMINATION AND STUDENT STATEMENT FORM

STUDENT INFORMATION		
Last Name:	First Name:	Middle Initial:
Drexel University ID:	DOB:	Date of Entry into Drexel:

Program *(check one)*: ☐ ACE ☐ Co-op ☐ CAT ☐ MSN: NP ☐ NS/ISPP ☐ PA ☐ MSN: Advanced Role ☐ HSAD ☐ DNP ☐ COFT ☐ NUAN ☐ PTRS ☐ DPT ☐ Other

TO BE COMPLETED BY HEALTH CARE EXAMINER

PHYSICAL EXAMINATION

A physical exam was conducted on the above individual within the past twelve (12) months *(please check one):*	Date of Physical Exam:

I have verified that the individual I have examined is the named individual on this physical examination and immunization form (7 total pages) and that the above tests/vaccinations were performed in this office/laboratory or that I have reviewed any documentation relative to the student's immunization record.

Health Care Examiner's Name (Please Print):

License #:	**Phone:**
Signature of Health Care Examiner:	**Date:**