Student Health Services
Student Faculty Center, Lower Basement Rm.43
3340 North Broad Street
Philadelphia, PA 19140

FALL 2016
Phone: (215) 707-4088
Fax: (215) 707-2708
Web: http://www.temple.edu/StudentHealth

IMMUNIZATION RECORD

(CIRCLE NAME OF SCHOOL)

DENTAL **COLLEGE OF HEALTH PROFESSIONS:** _____
(Name of Department)

MEDICINE **PHARMACY** **PODIATRY**

NAME:_____
LAST FIRST

SSN#: _____

DOB:_____/_____/_____

TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER
COPY OF LAB REPORTS REQUIRED

TUBERCULIN SKIN TEST (PPD) must be done in Student Health Services upon arrival to Campus.

TETANUS/DIPHTHERIA BOOSTER **DATE: _____**
REQUIRED WITHIN THE PAST 10 YEARS

HEPATITS B SURFACE AB (Blood test) **DATE: _____**
RESULT: reactive / non-reactive (please circle one)

HEPATITS B VACCINE SERIES: #1_____#2_____#3_____

MEASLES TITER (Blood test) **DATE: _____**
RESULT: positive / negative (please circle one)

MUMPS TITER (Blood test) **DATE: _____**
RESULT: positive / negative (please circle one)

RUBELLA TITER (Blood test) **DATE: _____**
RESULT: positive / negative (please circle one)

VARICELLA TITER (Blood test) **DATE:_____**
RESULT: reactive / non-reactive (please circle one)

IF NON-REACTIVE, 2 DOSES OF VARIVAX REQUIRED

#1_____#2_____
HISTORY OF DISEASE NOT ACCEPTABLE

MEDICAL PROVIDER'S SIGNATURE_____ DATE _____

ADDRESS _____

_____

PHONE (_____)_____