Return completed forms to:

Delaware Valley University
Student Health and Wellness Center
700 East Butler Avenue
Doylestown, PA 18901

Phone: 215-489-2252
Fax: 215-230-2990
Email: HealthCenter@delval.edu

Name_____ Date of Birth ____/____/_____

THIS FORM MUST BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER

Required Immunizations

A. MENINGOCCAL Quadrivalent (ACWY) ***Required*** **If the student first received the meningitis vaccine prior to turning 16 years of age, a second, or booster vaccine, is required.**

Dose #1 _____/_____/_____ Dose #2 _____/_____/_____

B. VARICELLA (Birth in the U.S. before 1980, a history of chicken pox, a positive varicella antibody, or ***TWO*** doses of vaccine meets the requirement.)

1. History of Disease Yes _____ No _____ or Birth in the U.S. before 1980 Yes _____ No _____

2. Varicella antibody ____/____/____ Result: Reactive _____ Non-reactive _____

3. Immunization (***Required 2 doses)*** a. Dose #1 _____/_____/_____ b. Dose #2 _____/_____/_____

C. M.M.R. (Measles, Mumps, and Rubella) Required ***(2 doses or positive Titers)***

1. Dose #1 ___/____/____ Dose #2 ____/____/___

2. MMR antibody ____/____/____ Result: Reactive _____ Non-reactive _____

D. TETANUS-DIPHTHERIA-PERTUSSIS ***Required*** Primary series with a booster Tdap and a TD/Tdap booster in the last ten years

1. Primary series completed ____/___/_____ 2. Tdap booster ____/____/____ 3. Td/Tdap booster within the last 10 years___/___/___

E. HEPATITIS B ***Required*** **(**Three doses of vaccine or positive hepatitis B surface antibody meets the requirement.)

1. Immunization (Hepatitis B) Dose #1 _____/_____/_____ Dose #2 _____/_____/_____ Dose #3 _____/_____/_____

2. Hepatitis B surface antibody Date ____/____/___ Result: Reactive _____ Non-reactive _____

F. POLIO ***Required*** Completion of primary series ☐ YES ☐ NO Date of last booster _____/_____/_____

Recommended

G. HUMAN PAPILLOMAVIRUS VACCINE (HPV) Dose #1 _____/_____/_____ Dose #2 ____/_____/____ Dose #3 _____/____/____

H. HEPATITIS A Dose #1 _____/_____/_____ Dose #2 _____/_____/___

I. MENINGOCOCCAL B _____ Dose #1 _____/_____/_____ Dose #2 _____/_____/_____ Dose #3 _____/____/____
name of vaccine

Tuberculosis Screening

(If the answer to question 1 or 2 is "Yes" proceed to additional evaluation to exclude active Tuberculosis disease)

1. Does the student have signs or symptoms of active pulmonary tuberculosis disease? Yes _____ No _____

2. Is the student a member of a high-risk group? Yes _____ No _____

3. Tuberculin Skin Test (PPD): Date: _____ Result: _____ (record actual mm of induration) _____Positive ____Negative

4. Interferon Gamma Release Assay (IGRA) Date Obtained: _____ Result: Positive_____ Negative ____
indeterminate___ borderline___ (T-Spot only)

5. Chest x-ray: (Required if TST or IGRA is positive): Date of chest x-ray: ___/___/____ Result: Normal____ Abnormal_____

Health Care Provider Name_____ **Signature**_____

Address_____ **Phone**_____ **Date**_____