

**Student Health and Wellness Center**

Office Hours: Monday – Friday 8:30 am to 4:30 pm

Phone Number: 215 489 2252

Fax Number: 215 230 2990

Email: healthcenter@delval.edu

Student Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

**This form must be completed and signed by your health care provider.**

**Required Vaccinations:**

1. Hepatitis B (three doses of vaccine or proof of positive Hepatitis B surface antibody titer)

Dose 1 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Dose 2 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Dose 3 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Hepatitis B surface antibody date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Result: Reactive \_\_\_\_\_ Non-reactive\_\_\_\_\_

2. Measles, Mumps, and Rubella (2 doses or positive titers)

Dose 1 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Dose 2 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

M.M.R. titer date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Result: Reactive\_\_\_\_\_ Non-reactive\_\_\_\_\_

3. Meningococcal Quadrivalent ACWY (If received a single dose before the age of 16 a second dose is required)

Dose 1 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Dose 2 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

4. Meningococcal B (two doses)

Name of the Meningococcal B vaccination \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dose 1 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Dose 2 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

5. Polio (three doses in primary series and one booster)

Dose 1 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Dose 2 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Dose 3 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Booster \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

6. Tetanus, Diphtheria, and Pertussis

DTaP Dose 1 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Dose 2 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Dose 3 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Dose 4 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Tdap Dose 1 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

7. Varicella (two doses of vaccine, history of chicken pox infection, or positive Varicella antibody titer)

Dose 1 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Dose 2 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Varicella antibody titer \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Result: Reactive \_\_\_\_\_ Non-reactive\_\_\_\_\_\_

History of chicken pox \_\_\_\_\_\_\_\_\_\_

**Recommended Vaccinations:**

1. COVID-19 (2 doses of Pfizer or Moderna or 1 dose of Johnson and Johnson)

Dose 1 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Dose 2 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

2. COVID-19 Booster(s)

Dose 1 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Dose 2 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

3. Human Papilloma Virus

Dose 1 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Dose 2 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Dose 3 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

4. Hepatitis A

Dose 1 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Dose 2 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

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**This form must be completed and signed by your health care provider.**

**Tuberculosis Screening:**

*If the answer to question 1 or 2 is “Yes” proceed to additional evaluation.*

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

2. Is the student a member of a high Tuberculosis risk group? Yes \_\_\_\_\_ No \_\_\_\_\_

3. Tuberculin Skin Test (PPD): Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Result: \_\_\_\_\_\_\_ mm Positive \_\_\_\_\_ Negative \_\_\_\_\_

4. Interferon Gamma Release Assay (IGRA): Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ Result: Positive \_\_\_\_\_\_ Negative \_\_\_\_\_\_

5. Chest X-ray (required if PPD or IGRA is positive): Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ Result: Normal \_\_\_\_\_\_ Abnormal \_\_\_\_\_\_

**Health Care Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Health Care Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date Form Completed: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_**

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