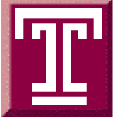

TEMPLE UNIVERSITY
A Commonwealth University

Student Health Services
Health Science Center
Student Faculty Center,
3340 N. Broad St.
Philadelphia, Pa. 19140
Tel: (215) 707-4088
Fax: (215) 707-2708

IMMUNIZATION FORM

(CIRCLE NAME OF SCHOOL)
DENTAL COLLEGE OF HEALTH PROFESSIONS

MEDICINE PODIATRY PHARMACY

NAME:____
LAST FIRST
SS#____

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.

MEASLES TITER (Blood test) DATE: _________
RESULT: positive / negative (please circle)

MUMPS TITER (Blood test) DATE: _________
RESULT: positive / negative (please circle)

RUBELLA TITER (Blood test) DATE: _________
RESULT: positive / negative (please circle)

HEPATITS B SURFACE AB (Blood test) DATE:________
RESULT: Reactive / non-reactive (please circle)

HEPATITS B VACCINE SERIES #1_________ #2________#3___________

VARICELLA TITER DATE:__________
RESULT: Reactive / non-reactive (please circle)
IF NEGATIVE 2 DOSES OF VARIVAX REQUIRED
#1__________________ #2__________________
HISTORY OF DISEASE NOT ACCEPTABLE

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

MEDICAL PROVIDER'S SIGNATURE_____________________________________ DATE ____________

ADDRESS AND PHONE ____

____