



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

FALL 2009
 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 (____) _____