



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

**FALL 2011**  
 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\****

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**MEDICAL PROVIDER'S SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

ADDRESS \_\_\_\_\_  
 \_\_\_\_\_

PHONE (\_\_\_\_) \_\_\_\_\_