University of Pennsylvania
Perelman School of Medicine

Visiting Student Application for Clinical Electives

Immunization Record

APPLICANT NAME: Last **First** **Birthdate**

The Perelman School of Medicine at the University of Pennsylvania requires that all visiting students meet all of the immunization requirements listed below. All applicants must submit this completed immunization form in order to be considered for an experience at Penn. This form must be completed, signed and dated by a health care provider. Applicants should be free from symptoms of infectious disease upon their arrival.

MEASLES, MUMPS, RUBELLA (MMR) Requirement: 2 doses of MMR vaccine are required. Dose 1 must be administered after the 1st birthday. Dose 2 must be administered at least 4 weeks after the 1st dose. Or submission of a blood test showing immunity if documentation of two dose completed series is unavailable.

MMR Dose 1_____Dose 2_____ ***OR***

MEASLES Dose 1_____Dose 2_____*OR* Blood Test: ☐ Positive Quantitative Result:_____Date_____Infection Date_____

MUMPS Dose 1_____Dose 2_____*OR* Blood Test: ☐ Positive Quantitative Result:_____Date Infection Date _____ Positive

RUBELLA Dose 1_____Dose 2_____*OR* Blood Test: ☐ Quantitative Result:_____Date _____

HEPATITIS B: 3 doses of Hepatitis B vaccine and a positive titer are required. Doses 1 and 2 must be administered at least 4 weeks apart. Dose 3 should be at least 6 months after the 1st dose and 8 weeks after the 2nd dose. The titer must be at least 4 weeks after the 3rd dose of Hep B vaccine. Select 1 of 3 below:

1) Three shot series plus positive titer

Dose 1_____Dose 2_____Dose 3_____ Hep B Surface Antibody: ☐ **Positive** Quantitative Result: _____ Date _____

2) Three shot series with negative titer. Repeat Hep B vaccine (Dose 4) then repeat titer in 4weeks. If the titer is positive, no further action needed. If the titer is negative, then continue with 2 more vaccines (doses 5 &6) in the repeat series and recheck titer 4 weeks after final vaccine dose 6.

Dose 1_____Dose 2_____Dose 3_____ Hep B Surface Antibody: ☐ **Negative** Quantitative Result: _____ Date _____

Dose 4_____Dose 5_____Dose 6_____ Hep B Surface Antibody: ☐ **Positive** Quantitative Result:_____ Date _____

3) Non-Responders – Three shot series completed twice with two negative titers- Then a Hepatitis B Surface Antigen Titer is needed

Dose 1_____Dose 2_____Dose 3_____ Hep B Surface Antibody: ☐ **Negative** Quantitative Result: _____ Date_____

Dose 4_____Dose 5_____Dose 6_____ Hep B Surface Antibody: ☐ **Negative** Quantitative Result:_____ Date _____

Hepatitis B Surface Antigen ☐ **Negative** Date_____ ☐ **Positive** Date_____
If positive needs Physician evaluation – must provide documentation

VARICELLA: 2 doses of varicella (chicken pox) vaccine are required. They must be administered at least 4 weeks apart. Or submission of a blood test showing immunity if documentation of two dose completed series is unavailable.

Dose 1_____Dose 2_____ **OR** Blood Test: ☐ Positive Quantitative Result_____Date:_____

TUBERCULOSIS: Results of last (2) PPD's OR (1) IGRA blood test are required. Any student with a positive reaction must forward the results of the evaluation, including results of a chest x-ray and subsequent management, along with this application. (2) PPD results within 12 months of each other with the most recent one within 6 months of the requested elective date. OR (1) IGRA result should be within the past 6 months.

Date of last PPD test _____ ☐ Negative ☐ Positive **If positive, chest x-ray/disease management report required** ☐

Date of previous PPD test _____ ☐ Negative ☐ Positive **If positive, chest x-ray/disease management report required** ☐

OR

IGRA (Interferon Gamma Release Assay) Blood test for TB infection.

☐ Negative ☐ Positive ☐Other (specify)_____; Date_____**If positive, chest x-ray/disease management report required** ☐

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MENINGOCOCCAL: One dose of Meningococcal vaccine is required if living in campus housing.
Dose 1_____

TETANUS-DIPHTHERIA AND PERTUSSIS (Tdap): (1) dose of adult Tdap. If last Tdap is more than 10 years old Td or Tdap vaccine booster is also required.

Tdap: Dose 1_____ Td or Tdap Vaccine booster (if more than 10 years since last Tdap) Date_____

INFLUENZA: (1) dose required each year. Annually after September 1st
Seasonal Flu Vaccine Date _____

COVID-19: (2) dose depending upon vaccine

☐ Pfizer ☐ Moderna

Dose 1_____Dose 2_____ Dose 3 (Recommended)_____

Health Care Provider

Print Name_____ **Phone #**_____

Signature_____ **Date**_____

Address_____