TEMPLE UNIVERSITY®

Student Health Services
Student Faculty Center, Lower Basement Rm.43
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Philadelphia, PA 19140

FALL 2022
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IMMUNIZATION RECORD

(CIRCLE NAME OF SCHOOL)

DENTAL MEDICINE PHARMACY PHYSICIAN ASSISTANT PODIATRY

COLLEGE OF HEALTH PROFESSIONS: _____
(Name of Department)

NAME: _____
LAST FIRST

TU ID#: _____ DOB: _____/_____/_____

TUBERCULIN SKIN TEST (PPD) Placement Date: _____/_____/_____ Read Date: _____/_____/_____

Reading: _____mm induration

OR

Quantiferon Test: DATE: _____/_____/_____ (attach lab report)

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

HEPATITIS B VACCINE SERIES: #1_____/_____/_____ #2_____/_____/_____ #3_____/_____/_____

****HEPATITIS B SURFACE AB, Quantitative (Blood test) DATE: _____/_____/_____ (attach lab report)**

(if non-reactive) Hepatitis B Booster: #4_____/_____/_____ #5_____/_____/_____ #6_____/_____/_____

REPEAT TITER DATE: _____/_____/_____

MMR VACCINE SERIES: #1_____/_____/_____ #2_____/_____/_____

****MEASLES TITER, Quantitative (Blood test) DATE: _____/_____/_____ (attach lab report)**

****MUMPS TITER, Quantitative (Blood test) DATE: _____/_____/_____ (attach lab report)**

****RUBELLA TITER, Quantitative (Blood test) DATE: _____/_____/_____ (attach lab report)**

(if negative) MMR BOOSTER: _____/_____/_____

VARICELLA VACCINE SERIES: #1_____/_____/_____ #2_____/_____/_____
(HISTORY OF DISEASE NOT ACCEPTABLE)

****VARICELLA TITER, Quantitative (Blood test) DATE: _____/_____/_____ (attach lab report)**

(if non-reactive) VARICELLA BOOSTER**:** _____/_____/_____

******QUANTITATIVE LAB REPORTS REQUIRED FOR ALL TITERS; QUALITATIVE RESULTS WILL NOT BE ACCEPTED******

MEDICAL PROVIDER'S SIGNATURE_____ DATE _____

ADDRESS _____

_____

PHONE (_____)_____