Cabrini University Immunization Record

Mail to: 610 King of Prussia Rd, Radnor, PA 19087 **ATTN: Health Services**
OR Fax to: 610-902-8282
OR Email to: healthservices@cabrini.edu

ALL HEALTH FORMS ARE DUE BY: July 15th (For Fall Semester)
Jan 15th (For Spring Semester)

Last Name:		**First Name:**	
Cabrini ID *8-digits:*	**Email:**	**Student Cell Number:**	**Date of Birth:** _____/____/____ Month Day Year

REQUIRED IMMUNIZATIONS:

1. Tetanus/ Diphtheria- Completed primary series:
   Month_____ Day_____ Year_____
   Tdap booster within last 10 years - **required:**
   Month_____ Day_____ Year_____

2. Polio- Completed primary series - **required:**
   Type of vaccine_____ OPV and / or _____ IPV
   Month_____ Day_____ Year _____

3. MMR 2 doses after 12 months of age - **required:**
   Month_____ Day_____Year _____(1st dose)
   Month_____ Day_____ Year _____(2nd dose)

4. Hepatitis B Vaccine Series - **required:**
   Month_____ Day_____ Year _____ (1st dose)
   Month_____ Day_____ Year _____ (2nd dose)
   Month_____ Day_____ Year _____ (3rd dose)

5. Varicella Vaccine Series - **required:**
   Month_____ Day____ Year _____(1st dose)
   Month_____ Day____ Year _____(2nd dose)

   If history of illness, titer is required:
   Reactive _____ Non-reactive _____

6. Meningococcal Vaccine A, C, Y, and W-135 **OR** Menactra Vaccine-**required- within last 5 yrs *:**
   Month_____ Day____ Year _____
   * One dose required **ON** or **AFTER** 16th birthday

7. Meningococcal Group B Vaccine Series-**required**
   Month_____Day____Year_____ (1st dose)
   Month _____ Day____ Year_____ (2nd dose)
   Month _____ Day____ Year_____ (3rd dose) *

   *3rd dose, IF NEEDED – **Trumenba only**

RECOMMENDED IMMUNIZATIONS:

Hepatitis A Vaccine Series (2 doses) - recommended:
Month_____Day_____Year_____ (1st dose)
Month_____Day_____Year_____(2nd dose)

HPV Vaccine Series (2-3 doses) - recommended:
Month_____Day_____Year_____(1st dose)
Month_____Day_____Year_____ (2nd dose)
Month_____Day_____Year _____(3rd dose IF NEEDED)

Influenza Vaccine (most recent) – recommend annually:
Month_____ Day _____ Year _____

PLEASE SEE OTHER SIDE OF THIS FORM FOR TUBERCULOSIS (TB) TESTING INFORMATION AND REQUIRED STUDENT QUESTIONNAIRE

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PPD/Tuberculin Skin Test

Is student a member of a high risk group?
Please see targeted testing guidelines at:
www.cdc.gov/tb/publications/ltbi/targetedtesting.htm

Date Placed: Month____ Day____ Year _____
Date Read: Month____ Day____ Year_____

Result: _____mm induration
_____Positive _____Negative

TUBERCULOSIS (TB) RISK QUESTIONNAIRE **Required** - To be completed by ***ALL*** students:

1. Have you ever had a positive tuberculosis skin test or blood test in the past? ☐ Yes ☐ No
2. To the best of your knowledge, have you ever had close contact with anyone who was sick with TB? ☐ Yes ☐ No
3. Were you born in one of the countries listed below? * ☐ Yes ☐ No
4. Have you traveled or lived for more than one month in any of the countries listed below? * ☐ Yes ☐ No
5. Have you ever had changes on a prior chest x-ray suggesting inactive or past TB disease? ☐ Yes ☐ No
6. Do you have a medical condition associated with increased risk of progressing to TB disease if infected, such as diabetes, chronic renal failure, leukemia or lymphomas, low body weight, HIV/AIDS, gastrectomy or intestinal bypass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone >15 mg/day for >1 month), other immunosuppressive disorders, or are you an organ transplant recipient? ☐ Yes ☐ No
7. Have you been a volunteer, employee or resident in a high-risk congregate setting such as a prison, nursing Home, hospital, homeless shelter, residential facility or other health care facility in the past 12 months? ☐ Yes ☐ No
8. Do you have a history of illicit drug use? ☐ Yes ☐ No

* Angola, Bangladesh, Brazil, Central African Republic, China, Congo, DPR Korea, DR Congo, Ethiopia, India, Indonesia, Kenya, Lesotho, Liberia, Mozambique, Myanmar, Namibia, Nigeria, Pakistan, Papua New Guinea, Philippines, Russian federation, Sierra Leone, South Africa, Thailand, Ukraine, UR Tanzania, Viet Nam, Zambia, Zimbabwe

If you answer NO to all of the above questions, no further action is required. If you answer **YES** to any of the above questions, you are required to have a Mantoux tuberculin skin test (TST) or TB blood test (IGRA) *within 6 months prior to beginning classes.* Prior BCG does not exempt students from this requirement. If your TST or TB blood test is positive, please attach chest x-ray results that were completed in the USA. All TB testing must be the same day or 28 days after any live vaccines.

TB SKIN TEST- Use Mantoux test only

Date Planted: ___/_____/____ Interpretation: Neg. ☐
Date Read: ___/_____/____ Pos. ☐

_____mm induration
(if no induration, mark "0")

-OR- **TB BLOOD TEST**

Quantiferon: ☐*
T-Spot: ☐*
Date: ____/____/____

Result: Neg. ☐ Pos.. ☐
Enclose copy of lab report

CHEST X-RAY*
Chest X-Ray Date

____/____/_____
☐ Normal ☐ Abnormal

Enclose copy of USA X-Ray Report

MEDICATION TREATMENT FOR TB:

Drug:_____
Dose & Frequency_____
Treatment Start Date: ___/___/___
End Date: ____/____/_____

Healthcare Provider Name	**Provider Signature**	**Date**
Provider Address	**Provider Telephone**	**Provider Fax**