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
IMPORTANT! Due by July 15 (Fall semester) **Jan 15** (Spring Semester)

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

Required Immunizations

Hepatitis B 3 doses of vaccine ***or*** a blood test showing immunity.	**Dose 1** ___/__/___ Month Day Year	**Dose 2** ___/__/___ Month Day Year		**Dose 3** ___/__/___ Month Day Year
Measles, Mumps, Rubella 2 doses of vaccine ***or*** a blood test showing immunity.	**MMR Dose 1** ___/__/____ Month Day Year	**MMR Dose** ____/__/__ Month Day Year	OR	**Titer Date** **Result**________ ___/___/___
Meningococcal (serogroups **A, C, Y, and W-135 *required***) 1 dose on or after 16th birthday.		**Meningococcal Last Dose** ___/__/___ Month Day Year	**Office Use only** **Email sent**___________________ **Booster received** ____________________	
Tetanus-Diphtheria and Pertussis (Tdap) - must be within 10 years Incoming students must have proof of Tdap (tetanus toxoid, reduced diphtheria toxoid and acellular pertussis vaccine) immunization. **Td (tetanus- diphtheria) does not satisfy this requirement.**				**Tdap** ___/__/___ Month Day Year
Varicella (Chicken Pox) 2 doses of vaccine ***or*** history of illness, ***or*** a blood test showing immunity.	**Dose 1** __/__/___ Month Day Year	**Dose 2** ___/__/___ Month Day Year	OR	**Varicella Illness** __/__/____ Month Day Year

Recommended Immunizations

Influenza Vaccine (Most recent)	___/____/_____ Month Day Year		
Hepatitis A vaccine – 2 doses	**Dose 1** ___/__/___ Month Day Year	**Dose 2** ___/__/___ Month Day Year	
HPV Vaccine – 3 doses	**Dose 1** ___/__/___ Month Day Year	**Dose 2** ___/__/___ Month Day Year	**Dose 3** ___/__/___ Month Day Year
Meningitis B Vaccine – Trumenba OR Bexsero	**Dose 1** ___/__/___ Month Day Year	**Dose 2** ___/__/___ Month Day Year	**Dose 3 Trumenba if indicated**___/__/____ Month Day Year
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 _______

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