



Summer Program Student Health Record (Page 1 of 6)

**REQUIREMENTS FOR SUMMER PROGRAM PARTICIPANTS**

*(These requirements pertain to summer program students only. Full-time program students who enter in the summer are subject to the same requirements as students starting in the fall or spring)*

- Students must complete and submit the Summer Program Student Health Record. The deadline is June 1, 2009.
- Students who require additional evaluation for tuberculosis will be contacted by us to arrange follow-up at Student Health for a PPD skin test. **Prior testing will *not* be accepted.**

**Measles, Mumps and Rubella (MMR)**

Two doses of MMR (*or* two doses of measles, *plus* one dose of mumps, and *plus* one dose of rubella *or* blood tests showing immunity).

**Chicken Pox (Varicella)**

Two doses of chicken pox vaccine at least one month apart (one dose if before age 13) *or* positive immune titer verifying immunity *or* history of disease.

**Meningococcal**

One dose of Meningococcal vaccine is required for all incoming pre-college and undergraduate students living in campus housing.

**RECOMMENDED IMMUNIZATIONS FOR SUMMER PROGRAM PARTICIPANTS**

**Hepatitis B**

Doses one and two given four weeks apart, dose three given at least five months from the second dose is recommended.

**Tetanus-Diphtheria-Pertussis (Tdap)**

It is strongly recommended that students whose last Td (Tetanus-Diphtheria) immunization was more than five years ago receive a booster with Tdap (Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine).

StudentName \_\_\_\_\_  
 Date Of Birth \_\_\_\_\_  
 Student ID \_\_\_\_\_

The Deadline for submission of this form is June 1, 2009

Please mail this form to:  
Immunization Compliance Office  
Student Health Services  
3535 Market street Philadelphia,  
PA 19104 Fax: 215 746 0909

**Health History - Please check all boxes that apply. (Page 2 of 6)**

**Alcohol/Drug/Tobacco Consumption**

- Advised to seek alcohol counseling
- Recreational drug use
- Smoking/tobacco use
- Sought counseling about alcohol consumption

**Eating Disorders**

- Anorexia
- Bulimia
- Obesity

**Medication**

- Nonprescription medications
- Prescription medications
- Regular vitamins

**Serious or Chronic Medical Conditions**

- Cancer/malignancy
- Chronic fatigue
- Diabetes
- Hearing disabilities
- Heart disease
- High blood pressure
- Kidney disease
- Limited physical activity
- Migraines

**Allergies**

- Environmental allergies
- Food allergy
- Medication allergy/reaction
- Other known allergy
- Reaction to insect bites

**Infectious Diseases**

- Hepatitis B infection
- Hepatitis C infection
- HIV infection
- Mononucleosis
- Sexually transmissible infection
- Tropical diseases

**Other**

- Head injury/unconsciousness
- Loss of vital organ
- Major Surgery or serious injury
- Other
- Victim of assault/rape
- Neurological disorder
- Serious blood disorders/anemia
- Serious gastrointestinal conditions
- Serious respiratory disorders/asthma
- Vision corrective lens
- Seizures
- Menstrual cycle disorders

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**Tuberculosis Screening (Page 3 of 6)**

Answer the questions below. The University of Pennsylvania does not accept outside TB screen results. If you are required to have a PPD test you must make an appointment at SHS.

1: Have you ever been in close contact with anyone with active tuberculosis?

Yes\_\_\_ No\_\_\_

2: Have you ever worked or done volunteer work that entailed direct contact with people in prisons?

Yes\_\_\_ No\_\_\_

3: Have you ever worked or done volunteer work that entailed direct contact with the homeless?

Yes\_\_\_ No\_\_\_

4: Have you ever worked or done volunteer work that entailed direct contact with refugees?

Yes\_\_\_ No\_\_\_

5: Have you ever worked or done volunteer work that entailed direct contact with people in hospitals or medical clinics?

Yes\_\_\_ No\_\_\_

6: Have you been diagnosed with diabetes?

Yes\_\_\_ No\_\_\_

7: Have you been diagnosed with cancer?

Yes\_\_\_ No\_\_\_

8: Do you have a history of prolonged use of corticosteroids and/or immunosuppressive treatment?

Yes\_\_\_ No\_\_\_

9: Do you have HIV?

Yes\_\_\_ No\_\_\_

10: **Country of Origin:**

Tuberculosis screening is required if you are coming from any country **EXCEPT** those on the following list:

American Region	European Region		Western Pacific Region
Canada Jamaica Saint Kitts and Nevis Saint Lucia USA Virgin Islands (USA)	Belgium Denmark Finland France Germany Greece Iceland Ireland Italy Liechtenstein	Luxembourg Malta Monaco Netherlands Norway San Marino Sweden Switzerland United Kingdom	American Samoa Australia New Zealand

Please check here if your country of origin is **not** on the list above \_\_\_\_\_

Name of your country of origin If not above \_\_\_\_\_

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**Requirements for summer session students (Page 4 of 6)**
**1. MEASLES, MUMPS, RUBELLA (MMR)**

Two doses of MMR are strongly recommended. Dose one of MMR must be administered after the first birthday, and the second given a minimum of four weeks later *or* two doses of measles given four weeks apart, two doses of mumps and one dose of rubella all administered after the first birthday *or* Positive titer showing immunity is also acceptable *or* disease history confirmed by your doctor's record for measles and mumps only, *history of rubella is not accepted.*

Dose 1 MMR			Dose 2 MMR		
Month	Day	Year	Month	Day	Year

Positive measles titer		
Month	Day	Year

History of measles infection		
Month	Day	Year

Dose 1 measles			Dose 2 measles		
Month	Day	Year	Month	Day	Year

Positive mumps titer		
Month	Day	Year

History of mumps infection		
Month	Day	Year

Dose 1 mumps			Dose 2 mumps		
Month	Day	Year	Month	Day	Year

Positive rubella titer		
Month	Day	Year

Dose 1 rubella		
Month	Day	Year

**2. CHICKEN POX (VARICELLA)**

Two doses of chicken pox vaccine are required at least one month apart (one dose is sufficient if given before age 14) *or* Positive titer verifying immunity is acceptable *or* History of disease.

Dose 1 varicella			Dose 2 varicella		
Month	Day	Year	Month	Day	Year

Positive varicella titer		
Month	Day	Year

History of varicella infection		
Month	Day	Year

**3. MENINGOCOCCAL**

One dose of Meningococcal vaccine (covering serogroups A,C,Y. and W-135) is required for all incoming undergraduate students living in campus housing. Incoming graduate students living in campus housing may satisfy this requirement either through immunization or by submitting the Meningococcal Waiver form found at <http://www.upenn.edu/shs/>

Dose 1 Meningococcal		
Month	Day	Year

**4. TUBERCULOSIS**

Students must complete all items in the Tuberculosis Screening Form (Page 3). Students who require additional evaluation will be contacted by us to arrange follow-up at Student Health for a PPD skin test. Prior PPD testing will not be accepted.

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**Recommended Immunizations for Summer Program Participants (Page 5 of 6)  
For immunization requirements, please see page 4.**

**HEPATITIS B**

Doses one and two given four weeks apart, dose three given at least five months from the second dose is recommended.

Hepatitis B Dose 1			Hepatitis B Dose 2			Hepatitis B Dose 3		
Month	Day	Year	Month	Day	Year	Month	Day	Year

History of hepatitis B titer		
Month	Day	Year

History of hepatitis B infection		
Month	Day	Year

**TETANUS-DIPHTHERIA-PERTUSSIS (Tdap)**

It is recommended that students whose last Td (Tetanus- Diphtheria) immunization was more than five years ago should receive a booster with Tdap (Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine).

Dose 1 Td		
Month	Day	Year

Dose 1 Tdap		
Month	Day	Year

**Exemptions**

Students are exempt from the immunization requirements if there is a medical contraindication or if religious or philosophical belief prohibits immunizations. A signed statement indicating specific medical contraindication from a Medical Doctor, Osteopath, Nurse Practitioner or a Physician's Assistant is required for medical exemption. A signed declaration of religious or philosophical belief must be submitted to SHS. If the exemption includes meningococcal vaccine, the Meningococcal Waiver must also be submitted. The Student Health History, Tb Screening and Consent Form still must be submitted.

**Health Care Provider Information**

Provider Name \_\_\_\_\_

Provider Signature \_\_\_\_\_

Provider Address \_\_\_\_\_ Provider Phone \_\_\_\_\_

**Patient Consent (Page 6 of 6)**

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PERMISSION FOR MEDICAL TREATMENT:

I hereby authorize the Student Health Service of the University of Pennsylvania to administer care and treatment.

Such care may include evaluation of treatment of injuries and illnesses and the administration of medication orally or by injection. I also give permission to the University of Pennsylvania and to the Student Health Service of the University of Pennsylvania to secure proper treatment for me, in case of medical or surgical emergency, if according to their best professional judgment, further delay might jeopardize my welfare.

PERMISSION FOR RELEASE OF INFORMATION:

I hereby authorize the Student Health Service to use and disclose my personal health information as allowed by law, including but not limited to for the following purposes:

- Providing health care to me. For example, we may share your health information with individuals or offices on or off campus who provide, or assist in coordination or management of, health care.
• Processing payment. For example, we may share your health information with insurance carriers for reimbursement purposes.
• So that we may run our operations. For example, we may use your health information to perform quality assessments and or conduct training.

Once my information is disclosed, it may no longer be protected by federal and/or state laws.

Special Protections for Certain Information

Information about HIV status, mental health, and/or substance abuse is subject to special privacy under state and/or federal law. Generally, the Student Health Service will not disclose such information unless you sign a specific authorization to do so, the disclosure is allowed by court order, or in limited and regulated other circumstances.

NOTICE OF PRIVACY PRACTICES:

I hereby acknowledge that I have received the enclosed Notice of Privacy Practices statement.

PLEASE PRINT CLEARLY

Student name \_\_\_\_\_

Signature of student \_\_\_\_\_

Parent/guardian name \_\_\_\_\_

Signature of parent/guardian \_\_\_\_\_ Date \_\_\_\_\_

EMERGENCY CONTACT INFORMATION

Emergency contact information Alternate emergency contact information

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Daytime Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_

StudentName \_\_\_\_\_

Date Of Birth \_\_\_\_\_

Student ID \_\_\_\_\_

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