IMMUNIZATION RECORD

Student ID 8 digits:
Necessary for all students
1 4 6 0 1 7 8 5

Only submit completed forms, as incomplete forms are discarded by the system.

PART 1: COMPLETED BY THE STUDENT. ALL INFORMATION MUST BE PRINTED LEGIBLY OR FORM CANNOT BE PROCESSED.

Last Name: Chowdhury	First Name: Priontu	Middle Initial
DOB: 08/21/1996	Drexel Start Date: 09 month 2022 year	Email address: pc833@drexel.edu
Full Mailing Address: 4233 Chestnut Street APT 442 (Street Address)	Philadelphia (City)	Pennsylvania (State) 19104 (ZIP Code)
Please Check: ✓ University Housing ___ Commuter	Please Check ✓ Undergraduate ___ Graduate	Please Check: ___ Domestic ✓ International

PART 2: TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER.

A. **TUBERCULOSIS – PLEASE SEE ATTACHMENT 1 TO COMPLY WITH THIS REQUIREMENT. ALL STUDENTS MUST UPLOAD PART 1 ALONG WITH THIS FORM.**
Quantiferon Gold test advised 10/19/2022.

B. **TDAP - Required within last 10 years.**
All students must have proof of Tdap dated 2005 or later. Td does not satisfy this requirement. Td booster is required if Tdap is older than 10 years
TDAP: 10/19/2022 Td:
Tdap last current within 10 years and no Td booster record.

C. **MMR (Measles, Mumps, Rubella) - Two doses of vaccine OR blood test showing immunity COPY OF LAB REPORT REQUIRED.**
Measles only: 7/13/97 and 8/15/97
1st dose date: Never received MMR vaccine, 10/19/2022
2nd dose date (minimum of four weeks after dose 1):

D. **VARICELLA (Chicken Pox) Complete ONE of the following: history of disease, OR two doses of vaccine OR blood test showing immunity COPY OF LAB REPORT IS REQUIRED.**
History of disease: ☐ Yes OR ☐ No
Never received Varicella vaccine,
Vaccination 1st dose date: 10/19/2022
Vaccination 2nd dose date (minimum of four weeks after dose 1):

E. **HEPATITIS B - Completion of at least two of three required for compliance (three doses required to complete the series) OR blood test showing immunity COPY OF LAB REPORT REQUIRED.**
Vaccination 1st dose date: 10/4/96 ★ Error? 4/10/96 AB 10/19/22
Vaccination 2nd dose date (minimum of four weeks after dose 1): 6/4/96 Error? AB 10/19/22 11/6/96 ★
Vaccination 3rd dose date (minimum of eight weeks after dose 2 and a minimum of 16 weeks after dose 1): 01/02/97 Error? AB 10/19/22 02/01/97 ★

F. **MENINGOCOCCAL - Required for all full-time undergraduate students age 21 or younger and all students living in University housing. Meningococcal Quadrivalent**: (MCV4, such as Menactra or Menveo) since age 16
Quadrivalent conjugate (circle one): Menactra Menveo
Date given: Never received
Age 26
Living off campus → Not required

G. **HEALTH CARE EXAMINER'S STATEMENT: I HAVE VERIFIED THAT THE INDIVIDUAL I HAVE EXAMINED IS THE NAMED INDIVIDUAL ON THIS FORM AND THAT THE ABOVE TESTS/VACCINATIONS WERE PERFORMED IN THIS OFFICE/LABORATORY, OR I HAVE REVIEWED ANY DOCUMENTATION RELATIVE TO THE STUDENT'S IMMUNIZATION RECORD**

License #: PA #OS019497	Phone: 215-220-4700
Signature of Healthcare Examiner:	Date: 10/19/2022

PART 3: TO BE SIGNED BY THE STUDENT - FORM CANNOT BE PROCESSED WITHOUT STUDENT SIGNATURE

April Barnum, DO, CAQSM
Family Medicine/Sports Medicine
Pennsylvania License: OS019497
NPI: 1265811814
DEA: FB7927342
Drexel Student Health Center
3401 Market Street, Suite 1058
Philadelphia, PA 19104

Student Signature _____ Student ID# (8 digits) 14601785

The information provided on this form is correct. I understand that failure to complete this form correctly may jeopardize my student standing at Drexel University. I will submit the form using the directions provided on information sheet. **College of Nursing and Health Professions:** I understand that this form meets University requirements, however, if there are additional program requirements that must also be satisfied I will access them at **drexel.edu/cnhp/about/compliance/complianceforms** and forward them to my program.

PLEASE VISIT DREXEL.EDU/HII FOR ANY UPDATES REGARDING DREXEL UNIVERSITY'S IMMUNIZATION REQUIREMENTS.

TOOL FOR INSTITUTIONAL USE

Part I. Tuberculosis (TB) Screening Questionnaire (to be completed by incoming students)

Please answer the following questions:

1: Have you ever had close contact with persons known or suspected to have active TB disease? ☐ Yes ☑ No

2: Were you born in one of the countries or territories listed below that have a high incidence of active TB disease? ☑ Yes ☐ No
(If yes, please CIRCLE the country, below)

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
China, Hong Kong SAR
China, Macao SAR
Colombia
Comoros
Congo
Côte d'Ivoire
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Ethiopia
Fiji
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Mexico
Micronesia (Federated States of)
Mongolia
Montenegro
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
New Caledonia
Nicaragua
Niger
Nigeria
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Sao Tome and Principe
Senegal
Serbia
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Swaziland
Syrian Arab Republic
Tajikistan
Tanzania (United Republic of)
Thailand
Timor-Leste
Togo
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Vietnam
Yemen
Zambia
Zimbabwe

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2015. Countries with incidence rates of 20 cases per 100,000 population.

Bangladesh

3: Have you had frequent or prolonged visits* to one or more of the countries or territories listed above with a high prevalence of TB disease? (If yes, CHECK the countries or territories, above) ☑ Yes ☐ No

4: Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? ☐ Yes ☑ No

5: Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease? ☐ Yes ☑ No

6: Have you ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol? ☐ Yes ☑ No

If the answer is YES to any of the above questions, Drexel University requires that you receive TB testing as soon as possible.

If the answer to all of the above questions is NO, no further testing or further action is required.

* The significance of the travel exposure should be discussed with a health care provider and evaluated.

Student Signature: _____ Date: 08/28/2022

Part II. Clinical Assessment by Health Care Provider

Clinicians should review and verify the information in Part I. Persons who answered NO to all questions in Part I do not need further testing. Persons who answered YES to any of the questions in Part I are candidates for either the Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented.

- History of a positive TB skin test or IGRA blood test? (If yes, document below.) ☐ Yes ☑ No
- History of BCG vaccination? (If yes, consider IGRA if possible.) ☑ Yes ☐ No

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1. TB SYMPTOM CHECK

Does the student have signs or symptoms of active pulmonary tuberculosis disease? ☐ Yes ☑ No

If No, proceed to 2 or 3.

If yes, check below:

- ☐ Cough (especially if lasting for 3 weeks or longer) with or without sputum production
- ☐ Coughing up blood (hemoptysis)
- ☐ Chest pain
- ☐ Loss of appetite
- ☐ Unexplained weight loss
- ☐ Night sweats
- ☐ Fever

Proceed with additional evaluation to exclude active tuberculosis disease, including tuberculin skin testing, chest X-ray, and sputum evaluation as indicated.

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2. TUBERCULIN SKIN TEST (TST): MUST BE PERFORMED IN THE UNITED STATES (IF CURRENTLY LIVING OUTSIDE OF THE UNITED STATES, GO TO #3).

(TST result should be recorded as actual millimeters [mm] of induration, transverse diameter; if no induration, write "0." The TST interpretation should be based on mm of induration as well as risk factors.)**

Date Given: ____/____/____ (M D Y) Date Read: ____/____/____ (M D Y) N/A

Result: _____ mm of induration **Interpretation: positive____ negative____ Quantiferon Gold test ordered.

Date Given: ____/____/____ (M D Y) Date Read: ____/____/____ (M D Y)

Result: _____ mm of induration **Interpretation: positive____ negative____

****INTERPRETATION GUIDELINES**

>5 mm is positive:

- recent close contacts of an individual with infectious TB
- persons with fibrotic changes on a prior chest X-ray, consistent with past TB disease
- organ transplant recipients and other immunosuppressed persons (including receiving equivalent of >15 mg/d of prednisone for >1 month)
- HIV-infected persons

>10 mm is positive:

- recent arrivals to the U.S. (<5 years) from high-prevalence areas or who resided in one for a significant* amount of time
- injection drug users
- mycobacteriology laboratory personnel
- residents, employees, or volunteers in high-risk congregate settings
- persons with medical conditions that increase the risk of progression to TB disease, including silicosis, diabetes mellitus, chronic renal failure, certain types of cancer (leukemias and lymphomas, cancers of the head, neck, or lung), gastrectomy or jejunoileal bypass and weight loss of at least 10% below ideal body weight.

>15 mm is positive:

- persons with no known risk factors for TB who, except for certain testing programs required by law or regulation, would otherwise not be tested.

* The significance of the travel exposure should be discussed with a health care provider and evaluated.

3. **INTERFERON GAMMA RELEASE ASSAY (IGRA): MAY BE COMPLETED OUTSIDE OF THE UNITED STATES BUT LAB REPORT IS REQUIRED IN ENGLISH.**

Date Obtained: 10/19/2022 (specify method) QFT-GIT T-Spot other_____
M D Y

Result: negative___ positive___ indeterminate___ borderline___ (T-Spot only)

Date Obtained: ____/____/____ (specify method) QFT-GIT T-Spot other_____
M D Y

Result: negative___ positive___ indeterminate___ borderline___ (T-Spot only)

4. **CHEST X-RAY: REQUIRED IF TST OR IGRA IS POSITIVE AND MUST BE PERFORMED IN THE UNITED STATES. LAB REPORT IS REQUIRED IN ENGLISH.**

Date of chest X-ray: ____/____/____ Result: normal_____ abnormal_____
M D Y

Part III. Management of Positive TST or IGRA

All students with a positive TST or IGRA with no signs of active disease on chest X-ray should receive a recommendation to be treated for latent TB with appropriate medication. However, students in the following groups are at increased risk of progression from LTBI to TB disease and should be prioritized to begin treatment as soon as possible.

- Infected with HIV
- Recently infected with M. tuberculosis (within the past 2 years)
- History of untreated or inadequately treated TB disease, including persons with fibrotic changes on chest radiograph consistent with prior TB disease
- Receiving immunosuppressive therapy, such as tumor necrosis factor-alpha (TNF) antagonists, systemic corticosteroids equivalent to/greater than 15 mg of prednisone per day, or immunosuppressive drug therapy following organ transplantation
- Diagnosed with silicosis, diabetes mellitus, chronic renal failure, leukemia, or cancer of the head, neck, or lung
- Have had a gastrectomy or jejunoileal bypass
- Weigh less than 90% of their ideal body weight
- Cigarette smokers and persons who abuse drugs and/or alcohol

☐ Student agrees to receive treatment

☐ Student declines treatment at this time

Health Care Professional Signature _____ Date 10/19/2022

April Barnum, DO, CAQSM
Family Medicine/Sports Medicine
Pennsylvania License: OS01045
NPI: 1265811814
DEA: FB7927342
Drexel Student Health Center
3401 Market Street, Suite 330B
Philadelphia, PA 19104

Immunization Summary

Priontu Chowdhury
MRN: 519524

Immunizations by Immunization Family

MMR	10/19/2022 (26 y.o.)	11/28/2022 (26 y.o.)
Tdap	10/19/2022 (26 y.o.)	
Varicella	10/19/2022 (26 y.o.)	11/28/2022 (26 y.o.)

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