

# 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: Priantu	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 19104 State ZIP Code
Please Check: <input checked="" type="checkbox"/> University Housing <input type="checkbox"/> Commuter	Please Check: <input checked="" type="checkbox"/> Undergraduate <input type="checkbox"/> Graduate	Please Check: <input type="checkbox"/> Domestic <input checked="" type="checkbox"/> International

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

<input checked="" type="checkbox"/> A.	<b>TUBERCULOSIS</b> - PLEASE SEE ATTACHMENT 1 TO COMPLY WITH THIS REQUIREMENT. ALL STUDENTS MUST UPLOAD PART 1 ALONG WITH THIS FORM. <i>Quantiferon Gold test ordered 10/19/2022</i>
<input checked="" type="checkbox"/> B.	<b>TDAP</b> - Required within last 10 years. <i>TDAP 10/19/2022</i> <i>Not current within 10 years and no record.</i>
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	
<input checked="" type="checkbox"/> C.	<b>MMR (Measles, Mumps, Rubella)</b> - Two doses of vaccine OR blood test showing immunity COPY OF LAB REPORT REQUIRED. <i>Never received MMR vaccine.</i> <i>7/13/97 and 8/15/97</i> 1 <sup>st</sup> dose date: <i>10/19/2022</i> 2 <sup>nd</sup> dose date (minimum of four weeks after dose 1):
<input checked="" type="checkbox"/> D.	<b>VARICELLA (Chicken Pox)</b> Complete ONE of the following: history of disease, OR two doses of vaccine OR blood test showing immunity COPY OF LAB REPORT IS REQUIRED. <i>Never received Varicella vaccine.</i> History of disease: <input type="checkbox"/> Yes OR <input checked="" type="checkbox"/> No Vaccination 1 <sup>st</sup> dose date: <i>10/19/2022</i> Vaccination 2 <sup>nd</sup> dose date (minimum of four weeks after dose 1):
<input checked="" type="checkbox"/> E.	<b>HEPATITIS B</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. <i>10/14/96</i> Vaccination 1 <sup>st</sup> dose date: <i>10/14/96</i> Vaccination 2 <sup>nd</sup> dose date (minimum of four weeks after dose 1): <i>6/14/96</i> Vaccination 3 <sup>rd</sup> dose date (minimum of eight weeks after dose 2 and a minimum of 16 weeks after dose 1): <i>6/20/97</i>
<input checked="" type="checkbox"/> F.	<b>MENINGOCOCCAL</b> - 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 <i>Age 26</i> Date given: <i>Never received</i> <i>Living off campus -&gt; Not required</i>
<input checked="" type="checkbox"/> G.	<b>HEALTH CARE EXAMINER'S STATEMENT:</b> 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 #: <i>PA #05019497</i> Phone: <i>215-220-4700</i> Signature of Healthcare Examiner: <i>[Signature]</i> Date: <i>10/19/2022</i>

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

Student Signature: <i>[Signature]</i>	Student ID# (8 digits): 14601785
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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](http://drexel.edu/cnhp/about/compliance/complianceforms) and forward them to my program.

PLEASE VISIT [DREXEL.EDU/HII](http://DREXEL.EDU/HII) FOR ANY UPDATES REGARDING DREXEL UNIVERSITY'S IMMUNIZATION REQUIREMENTS.

April Samum, DO, CAQSM  
Family Medicine/Sports Medicine  
Pennsylvania License: OS019-97  
NPE: 1265811814  
DEA: FB7927342  
Drexel Student Health Center  
3401 Market Street, Suite 1059  
Philadelphia, PA 19104

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

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

- 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.)
- History of BCG vaccination? (If yes, consider IGRA if possible.)

☐ Yes ☒ No  
☒ Yes ☐ No

### 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.

### 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

Result: \_\_\_\_ mm of induration

\*\*Interpretation: positive \_\_\_\_ negative \_\_\_\_

Date Given: \_\_\_\_/\_\_\_\_/\_\_\_\_  
M D Y

Date Read: \_\_\_\_/\_\_\_\_/\_\_\_\_  
M D Y

Result: \_\_\_\_ mm of induration

\*\*Interpretation: positive \_\_\_\_ negative \_\_\_\_

NIA

Quantiferon  
Gold  
test  
ordered.

#### \*\*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 jejunioileal 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: OS01945  
NPI: 1265811814  
DEA: F87927342  
Cross Student Health Center  
3401 Market Street, Suite 1000  
Philadelphia, PA 19104

# Immunization Summary

Priantu Chowdhury

MRN: 519524

## Immunizations by Immunization Family

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

# Immunization Summary

Priantu Chowdhury  
MRN: 519524

## Immunizations by Immunization Family

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

Name: Priontu Chowdhury | DOB: 8/21/1996 | MRN: 519524 | PCP: April Barnum, DO | Legal Name: Priontu Chowdhury

# QUANTIFERON TB GOLD - Details

## Comments from the Doctor's Office

Hi Priontu,

I have reviewed your lab results. Your Quantiferon Gold test (tuberculosis screening test) is negative (normal).

Kind regards,  
Dr. Barnum  
Drexel Student Health Center - Attending Physician

## Study Result

Narrative

Performed at: 01 - Labcorp Raritan  
69 First Avenue, Raritan, NJ 088691800  
Lab Director: Ashhad Mahmood MD, Phone: 8006315250

## Component Results

Component	Your Value	Standard Range	Flag
QFT INCUBATE	Your Value Incubation performed.		
QFT-TB GOLD PLUS	Your Value Negative	Standard Range Negative	

No response to M tuberculosis antigens detected.

Infection with M tuberculosis is unlikely, but high risk individuals should be considered for additional testing (ATS/IDSA/CDC Clinical Practice Guidelines, 2017). The reference range is an Antigen minus Nil result of <0.35 IU/mL.

Chemiluminescence immunoassay methodology

## General Information

Ordered by April Barnum, DO

Collected on 10/19/2022 1:30 PM from Blood, Venous (Blood)

Resulted on 10/21/2022 8:05 PM

Result Status: Final result

This test result has been released by an automatic process.

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Name: Priontu Chowdhury | DOB: 8/21/1996 | MRN: 519524 | PCP: April Barnum, DO | Legal Name: Priontu Chowdhury

# QFT-TB GOLD PLUS 182880 - Details

## Comments from the Doctor's Office

Hi Priontu,

I have reviewed your lab results. Your Quantiferon Gold test (tuberculosis screening test) is negative (normal).

Kind regards,  
Dr. Barnum  
Drexel Student Health Center - Attending Physician

## Study Result

Narrative

Performed at: 01 - Labcorp Raritan  
69 First Avenue, Raritan, NJ 088691800  
Lab Director: Ashhad Mahmood MD, Phone: 8006315250

## Component Results

Component	Your Value	Standard Range	Flag
QFT CRITERIA	Your Value Comment		
QuantIFERON-TB Gold Plus is a qualitative indirect test for M tuberculosis infection (including disease) and is intended for use in conjunction with risk assessment, radiography, and other medical and diagnostic evaluations. The QuantiFERON-TB Gold Plus result is determined by subtracting the Nil value from either TB antigen (Ag) value. The Mitogen tube serves as a control for the test.			
QFT TB1 AG VALUE	Your Value 0.01 IU/mL	Standard Range IU/mL	
QFT TB2 AG VALUE	Your Value 0.01 IU/mL	Standard Range IU/mL	

Component	Your Value	Standard Range	Flag
QFT NIL VALUE	<b>Your Value</b> 0.02 IU/mL	<i>Standard Range</i> IU/mL	
QFT MITOGEN VALUE	<b>Your Value</b> >10.00 IU/mL	<i>Standard Range</i> IU/mL	

General Information

Ordered by April Barnum, DO

Collected on 10/19/2022 1:30 PM

Resulted on 10/21/2022 8:05 PM

Result Status: Final result

This test result has been released by an automatic process.

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