Dartmouth College Health Service at Dick's House

7 Rope Ferry Road, Hanover, NH 03755 P:(603) 646-9404

DUE DATE: June 30, 2025

IMMUNIZATION FORM FOR GRADUATE STUDENTS

FIRST NAME	MI	LAST NAME	BIRTHDATE (MM/DD/YY)
Sruhari		Karthik	01/13/2000

sruhari.karthik.th@dartmouth.edu — CONTACT EMAIL

(+91) 9087908748 — CONTACT PHONE NUMBER

REQUIRED IMMUNIZATIONS

Vaccination	Date1: Month/Day/Yr	Date 2: Month/Day/Yr	Date 3: Month/Date/Yr	Date 4: Month/Date/Yr
Tetanus, Diphtheria, Pertussis Primary Series (DTap, DTP, or DT) 4-5 shot series received in early childhood.	03/01/2000	03/29/2000	04/10/2000	
Tdap Booster: Dartmouth requires a Tdap on/after age 11. A valid Tdap shot dated after 9/1/15 is also required. If Tdap was given after age 11 and after 9/1/15 it will meet both requirements	( ) International Student: Tdap not available in home country. Vaccine will be received at Dartmouth College.	06/17/2025 Tdap (Required)	/ / dT (If booster is something other than dT, please specify below) _____	
MMR Vaccine Two doses required (doses must be given at least 28 days apart beginning on or after 12 months of age).	11/08/2000	05/26/2001	The MMR vaccines may be substituted with 2 Measles, 2 Mumps and 1 Rubella vaccine, medically documented proof of disease OR laboratory evidence of immunity.	
MEASLES	/ /	/ /	( ) Titer:Must Attach Report / /	
MUMPS	/ /	/ /	( ) Titer:Must Attach Report / /	
RUBELLA	/ /	( ) Titer:Must Attach Report / /		
VARICELLA Health care provider documented incidence of disease OR two doses of vaccine OR positive titer.NO PROOF IS NEEDED IF BORN IN THE USA PRIOR TO 1980 (Vaccine doses must be given at least 28 days apart on or after 12 months of age)	11/01/2001	05/02/2001	Verified Date of Disease / /	( ) Titer:Must Attach Report

RECOMMENDED VACCINATIONS (NOT REQUIRED)

Vaccination	Date1: Month/Day/Yr	Date 2: Month/Day/Yr	Date 3: Month/Date/Yr	Date 4: Month/Date/Yr
Most Recent COVID Vaccination Booster	/ /		Manufacturer:	
Hepatitis A	/ /	/ /		
HPV4 ( ), HPV9 ( )	/ /	/ /	/ /	
Hepatitis B	/ /	/ /	/ /	
Polio Primary Series (OPV or IPV) 4-5 shots in early childhood	/ /	/ /	/ /	/ /
Meningococcal ACYW-135	/ /	/ /		
Meningococcal B	/ /	/ /		
Most Recent Influenza	/ /			

OTHER VACCINATIONS (NOT REQUIRED)

Vaccination	Date1: Month/Day/Yr	Date 2: Month/Day/Yr	Date 3: Month/Date/Yr	Date 4: Month/Date/Yr
BCG	/ /			
Typhoid Oral ( ) IM ( )	/ /	/ /		
Pneumococcal PCV 13( ) PCV 15 ( ) PPSV23 ( )	/ /	/ /	/ /	/ /
Rabies	/ /	/ /	/ /	/ /
Yellow Fever	/ /			
Japanese Encephalitis	/ /	/ /	/ /	
Jynneos (Orthopox Virus)	/ /	/ /		
Haemophilus Influenza Type B	/ /	/ /	/ /	/ /
Herpes Zoster	/ /	/ /		
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Health care provider signature/stamp (REQUIRED):

cBhathan B

SIGNATURE OF HEALTH CARE PROVIDER (MD / DO / PA / APRN / RN / LPN)

06/23/2025
DATE

provider/facility stamp here

PRINTED/TYPED NAME OF HEALTH CARE PROVIDER

+91 9880450383
TELEPHONE NUMBER

Dr. B. CHETHAN BHANDARY M.B.B.S., PGDMLE., (NLSIU).
Reg. No. 16828 (KMC), Medical Officer
Narayana Hrudayalaya Super Speciality
Clinic & Diagnostic Center, Electronic City,
Phase-1, BANGALORE-560100.

Instructions:

Health care provider:

1. Please complete this form ensuring patient is in compliance with all 'REQUIRED IMMUNIZATIONS'.
2. Please sign and date the form (above).
3. Please provide patient with the original or a copy of the completed form.
4. In lieu of this form an official signed copy of your immunization records (translated in English) will suffice the requirement.

Student:

1 Please use your copy of this form or immunization records to enter vaccine dates into the ONLINE Immunization Form located on our direct web link: https:\\healthservices.dartmouth.edu

2. Upload your immunization record or a completed copy of this form to the ONLINE student health portal. For questions please email: **Medical.records.for.student.health@dartmouth.edu**

3. **Both steps #1 and #2 are REQUIRED. You must enter immunization dates Online and upload a copy of this form or a copy of your immunization records to the student health web portal under the Immunization Forms Category.**

DO NOT MAIL OR EMAIL ANY DOCUMENTS

DARTMOUTH

Dartmouth College Health Service
5 – 7 Rope Ferry Road HB 6143
Hanover, New Hampshire 03755
(P) 603-646-9405
(F) 877-884-8110

TUBERCULOSIS SCREENING FORM

Student Name: Srihari Karthik **Date of Birth:** 01/13/2000

SECTION A COMPLETED BY STUDENT

1. Were you born in any of the countries listed on **page 2?** ✓ YES ___ NO
2. Have you lived or traveled for more than 1 month in any countries on **page 2?** ✓ YES ___ NO
3. Have you worked, volunteered, or lived in potentially high risk setting such as prison, a longterm care facility, a homeless shelter, residential facility, drug treatment center, or lived with person with HIV/AIDS? ___ YES ✓ NO
4. Have you had a recent or prolonged contact with someone with infectious or active Tuberculosis? ___ YES ✓ NO
5. Do you have history of a positive TB test? **(IF YES, PROCEED DIRECTLY TO SECTION C)** ___ YES ✓ NO

IF YOU ANSWERED "YES" to any of these questions you are required to submit a **Mantoux 5TU PPD** skin test **OR** an **Interferon Gamma Release Assay (IGRA).** These test must be administered within **6 months** prior to entrance to Dartmouth College. Have your health care provider complete and sign **Section B.**

IF YOU ANSWERED "NO" to all questions, **NO FURTHER ACTION IS REQUIRED.** Please sign, date and submit this form to the Medical Records Office.

STUDENT SIGNATURE: srihark. **DATE:** 06/23/2025

(BY SIGNING, I ATTEST THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE)

SECTION B TO BE COMPLETED BY HEALTH CARE PROVIDER *(IF POSITIVE RESULT, PROCEED TO SECTION C)*

- ***TB TESTING IS REQUIRED EVEN IF YOU HAVE HAD THE BCG VACCINE***
- ***A TEST > 10mm IS CONSIDERED POSITIVE TB FROM HIGH PREVALENCE COUNTRIES, > 5mm IF YOU ARE IMMUNOCOMPROMISED***

PPD TEST: Date Planted:_____ Date Read:_____ Induration:_____ mm. NEG:_____ POS:_____ **READ WITHIN 48-72 HOURS**

IGRA RESULTS: ***(LAB REPORT MUST BE ATTACHED):*** Positive:_____ Negative: YES Type: BLOOD Date: 06/23/2025

Dr. B. CHETHAN BHANDARY M.B.B.S., PGDMLE., (NLSIU).
Reg. No. 16829 (KMC). Medical Officer
Narayana Hrudayalaya Super Specialty
Clinic & Diagnostic Center, Electronic City
Phase-1, BANGALORE-560100.

Signature of Provider *MD/PA/APRN/RN* **Printed Name** **Date** 06/23/2025

SECTION C TO BE COMPLETED BY PROVIDER IF A POSITIVE TB TEST OR HISTORY OF TB

- If positive PPD, IGRA, or T-SPOT - ***MUST SUBMIT A CHEST X-RAY***
- Attach a copy of the chest x-ray report The chest x-ray must be dated within 6 MONTHS of entrance to Dartmouth.
- Did the patient receive TB therapy? .....**NO** .....**YES** - If yes, please provide the following:

  START DATE:..... **COMPLETION DATE:**..... **TYPE (MEDICATION):**.....
- Provide a clinical evaluation. Does the patient exhibit cough, hemoptysis, fever, chills, night sweats or weight loss?

  NO.....**YES**..... If yes, please describe .....

Signature of Provider *MD/PA/APRN/RN* **Printed Name** **Date**

If you were born in any of the **countries listed below or traveled/lived in any of these countries for more than one month**, you are REQUIRED to submit a Mantoux PPD skin test or a copy of an Interferon gamma release assay (IGRA). The test must have been performed within six months prior to your Dartmouth registration date.
Source: World Health Organization Global Tuberculosis Report 2021

https://www.who.int/news/item/17-06-2021-who-releases-new-global-lists-of-high-burden-countries-for-tb-hiv-associated-tb-and-drug-resistant-tb

ANGOLA
AZERBAIJAN
BANGLADESH
BELARUS
BOTSWANA
BRAZIL
CAMEROON
CENTRAL AFRICAN REPUBLIC
CHAD
CHINA
CONGO
DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA
DEMOCRATIC REPUBLIC OF THE CONGO
ETHIOPIA
GHANA
GUINEA-BISSAU
INDIA
INDONESIA
KAZAKHSTAN
KENYA
KYRGYZSTAN
LESOTHO
LIBERIA
MALAWI
MOZAMBIQUE
MYANMAR
NAMIBIA
NIGERIA
PAKISTAN
PAPUA NEW GUINEA
PERU
PHILIPPINES
REPUBLIC OF MOLDOVA
RUSSIAN FEDERATION
SOMALIA
SOUTH AFRICA
SWAZILAND
TAJIKISTAN
THAILAND
UGANDA
UKRAINE
UNITED REPUBLIC OF TANZANIA
UZBEKISTAN
VIETNAM
ZAMBIA
ZIMBABWE

PharmEasy Labs

NAME : SRIHARI KARTHIK(25Y/M)
REF. BY : SELF
TEST ASKED : QUANTIFERON - TB,VITAMIN D AND B12 COMBO

SAMPLE COLLECTED AT :
C-401 SHRIRAM SIGNIAA NEELADRI ROAD ELECTRONIC CITY PHASE 1 ELECTRONIC CITY BENGALURU

TEST NAME	Results	UNITS
TB - IGRA - QUANTIFERON		
NIL TUBE	0.33	IU/mL
TB-ANTIGEN	0.35	IU/mL
IGRA - RESULT	NEGATIVE	

INTERPRETATION

NIL TUBE IN IU/ml	ANTIGEN TUBE MINUS NIL TUBE in IU/ml	FINAL RESULT	INTERPRETATION
<= 10.00	< 0.438	Negative	M. Tuberculosis Infection Unlikely
	>=0.438 & < 25 % of Nil tube	Negative	M. Tuberculosis Infection Unlikely
	>= 0.438 & >=25 % of Nil Tube	Positive	M. Tuberculosis Infection likely
>10.00	Any Result	Indeterminate	This may be due to excessive levels of circulating gamma interferon or presence of heterophile antibodies

NOTE

1 This assay cannot differentiate between Latent infection and Active Tuberculosis
2 Magnitude of measured Gamma Interferon cannot be corelated with stage or degree of infection,level of immune responsiveness or likelihood of progression to active disease
3 False negative results maybe obtained if sample is taken prior to development of immune response. CDC recommends repeat test after 8 - 10 weeks in case of high suspicion of tuberculosis.
4 Immunocompromised patients can also show the false negativity
5 Negative result does not preclude the possibility of Mycobacterium tuberculosis infection / disease

COMMENTS

This assay is an indirect test for Mycobacterium tuberculosis infection including disease and is intended for use in conjunction with risk assessment, radiography and other medical and diagonostic evaluations.

~~ End of report ~~

Sample Collected on (SCT) : 17 Jun 2025 09:34
Sample Received on (SRT) : 18 Jun 2025 08:25
Report Released on (RRT) : 19 Jun 2025 16:00
Sample Type : LITHIUM HEPARIN
Labcode : 1806000243/DG007
Barcode : CU869196

Dr Renuka MD(Path)

Dr Arshiya MD(Path)

Note:- Underlined values are Critical Values, Clinician's attention required.

Clinically Tested by :Thyrocare Technologies Ltd

PharmEasy Labs
Registered Address: DOCON TECHNOLOGIES PRIVATE LIMITED, Office No 208, 209 & 210 Second floor, A wing, 'Dattani Plaza', Near East West Industrial Estate, Safed Pool, Saki Naka, Andheri (East), Mumbai - 400072
Lab Address: D-37/1. TTC MIDC, Turbhe. Navi Mumbai, 400703
7022 000 900