Student Health Service
University of Pennsylvania

Immunization Compliance Office
IMPORTANT! RECORDS ARE DUE BY July 1, 2020

This form is to be completed by a medical provider. *Incoming students must complete the immunization requirements before arriving on campus*. SHS Immunization appointments are limited.

Immunization Form for Non-Healthcare Students 2020-2021

STUDENTS: Use this page as a guide to complete the Online Immunization Compliance Form on the SHS Portal: https://shs.upenn.edu. It is recommended to submit your actual immunization records in addition to or instead of this worksheet. PLEASE NOTE: IF YOU SUBMIT THIS FORM ALONE AS YOUR PROOF OF IMMUNIZATION HISTORY, IT MUST BE SIGNED OR STAMPED BY YOUR MEDICAL PROVIDER. IF THIS FORM IS SUBMITTED WITHOUT A MEDICAL PROVIDER'S SIGNATURE OR STAMP, IT WILL NOT BE ACCEPTED.

LAST NAME:	FIRST NAME (and optional preferred name):	DATE OF BIRTH ***(MM/DD/YYYY)***:
EMAIL ADDRESS:	PENN IDENTIFICATION NUMBER ***(8 digits if known):***	

REQUIRED

MMR 2 DOSES REQUIRED OR INDIVIDUAL VACCINES AS LISTED BELOW. ADMINISTERED AFTER 1ST BIRTHDAY		DOSE #1	DOSE #2	
—OR—				
Measles (Rubeola) 2 DOSES REQUIRED. MUST BE ADMINISTERED AFTER 1ST BIRTHDAY		DOSE #1	DOSE #2	***OR*** LABORATORY EVIDENCE OF IMMUNITY ***UPLOAD LAB REPORT***
Mumps 2 DOSES REQUIRED. MUST BE ADMINISTERED AFTER 1ST BIRTHDAY		DOSE #1	DOSE #2	***OR*** LABORATORY EVIDENCE OF IMMUNITY ***UPLOAD LAB REPORT***
Rubella (German Measles) 1 DOSE REQUIRED. MUST BE ADMINISTERED AFTER 1ST BIRTHDAY		DOSE #1		***OR*** LABORATORY EVIDENCE OF IMMUNITY ***UPLOAD LAB REPORT***
Hepatitis B 3 DOSES REQUIRED	DOSE #1	DOSE #2	DOSE #3	***OR*** LABORATORY EVIDENCE OF IMMUNITY ***UPLOAD LAB REPORT***
Tetanus-Diphtheria-Pertussis (Tdap) ONE-TIME DOSE AFTER AGE 10 (ADACEL OR BOOSTRIX)		TDAP DATE	**Circle One: Tdap or Td** (IF TDAP IS GREATER THAN 10 YEARS)	LAST BOOSTER DATE
Varicella (Chicken Pox) 2 DOSES REQUIRED OR DATE OF ILLNESS	ILLNESS DATE	DOSE #1	DOSE #2	*OR* LABORATORY EVIDENCE OF IMMUNITY ***UPLOAD LAB REPORT***
Meningococcal ACYW-135 DOSE SINCE AGE 16 IF 21 OR YOUNGER LIVING IN CAMPUS HOUSING			LAST DOSE	LIST VACCINE NAME OR SEROGROUPS COVERED:_____

RECOMMENDED

THE VACCINES LISTED BELOW ARE RECOMMENDED BASED ON AGE OR DISEASE CRITERIA. PLEASE CHECK WITH YOUR CLINICIAN.			
Hepatitis A	DOSE #1		DOSE #2
HPV (Human Papillomavirus) ☐ HPV4 ☐ HPV9	DOSE #1	DOSE #2	DOSE #3

ADDITIONAL VACCINES

INFLUENZA VACCINE RECOMMENDED ANNUALLY			
Other LIST VACCINE NAME:_____	DOSE #1	DOSE #2	DOSE #3
Other LIST VACCINE NAME:_____	DOSE #1	DOSE #2	DOSE #3
Other LIST VACCINE NAME:_____	DOSE #1	DOSE #2	DOSE #3

PROVIDER INFORMATION

SIGNING PROVIDER IS VERIFYING ALL DATES ABOVE ARE ACCURATE		
Provider Name (Please Print)		**Title**
Address	**Phone**	**Date**
Signature	**Clinical or Organization Stamp**	