The Penn State Hershey Medical Center Employee Health Department
Affiliated Student/Visitor Infectious Disease Summary

(In order to participate in a clinical experience/observation in patient care areas it is necessary that the following information be provided and verified by your family physician and/or school nurse)

ATTENTION! **This form must be submitted one month prior to student's start date to allow time for review and approval or notification if additional serology or vaccinations are required. No individual may affiliate unless all health requirements are meet.**

Student Name: **Birthdate:** **Phone Number:**
Email Address:
Affiliating School/Program: **Program Director and Phone#**
Start Date at HMC: **End Date at HMC:**
Department: **HMC Contact:**

List the countries that you have resided in, visited or transited through in the past 30 days:

TUBERCULOSIS:
Date and result of IGRA (Quantiferon or T Spot) blood test**:** **Date**__/__/__ **Result** Pos/Neg
OR
Date and result of last 2 TB skin tests:
PPD/ Skin Test 1) Date__/__/__
Results: Negative ____________
Positive ____________m.m.
PPD/ Skin Test 2) Date__/__/__
Results: Negative ____________
Positive ____________m.m.
IF POSITIVE:
Date of Chest X-Ray ______ (*must be within 2 years*)
Result ___________________
OR/ Isoniazid Prophylaxis Rx
____ NO
____ YES/DATE___________

Rubella (German Measles)
Antibody Titre by Lab Screen
Date _____________ Titre: Positive ___
Negative ___
Rubeola (Measles)
Antibody Titre by Lab Screen
Date _____________ Titre: Positive ___
Negative ___
Mumps
Antibody Titre by Lab Screen
Date_________________Titre: Positive___
Negative___

If any of the titres are negative, vaccination will be needed prior to start date

IMMUNIZATIONS:
Adult or child tetanus, diphtheria, pertussis (TDAP) – Date_________

Hepatitis B – Date(s) _______________
(not required by highly recommended for students affiliating in areas where there is potential for exposure to blood and/or body fluids).

Current Flu Vaccine- Date ________
(**Required October to March**)

Varicella (Chicken Pox)
Two (2) doses of vaccine
Dates ___________ & ___________
OR
Antibody Titre by Lab Screen
Date ___________Titre: Positive ___
Negative ___

HISTORY OF VARICELLA DISEASE
NOT ACCEPTED !

OR

MMR (Measles, Mumps & Rubella)
Documentation of two (2) doses of vaccine
Dates ____________ & _____________

Signature of Physician or Nurse: ___________________________**Date:**_________

Address: ____