

Student Health Services Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

800 East Lancaster Ave Villanova, PA 19085 Student ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone 610-519-4070 Student Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Website: villanova.edu/studenthealthservices Student Cell Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Send us a message: [studenthealthcenter@villanova.edu](mailto:studenthealthcenter@villanova.edu) Student Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student portal: [villanova.medicatconnect.com](https://villanova-my.sharepoint.com/personal/jappelba_villanova_edu/Documents/New%20student%20medical%20information/villanova.medicatconnect.com)

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| The Commonwealth of Pennsylvania and Villanova University require full-time students, part-time students, and all students on a visa to be immunized against certain communicable diseases. All dates must include month, day, and year. To comply, have this form completed and signed by your health care provider. As another option, you may provide official immunization documentation from your provider’s office. Please upload the completed form or documentation from your provider’s office to the Student Health Portal at [villanova.medicatconnect.com](https://villanova-my.sharepoint.com/personal/jappelba_villanova_edu/Documents/New%20student%20medical%20information/villanova.medicatconnect.com). Forms are to be uploaded by July 1, 2023. Failure to submit a completed health record will result in the inability to register for second semester classes. | | |
| **Required Vaccines** | **Dates Given (mm-dd-yyyy)** | **PA State Requirements** |
| **Hepatitis B**  Series of 3 immunizations – laboratory evidence of immunity is acceptable in lieu of immunization dates. | #1: \_\_\_\_\_\_\_\_\_\_\_  #2: \_\_\_\_\_\_\_\_\_\_\_  #3:\_\_\_\_\_\_\_\_\_\_\_\_  Or Positive Titer Date: \_\_\_\_\_\_\_\_\_\_\_ | Dose #1: Any age  Dose #2: 28 days after dose #1  Dose#3: at least 8 weeks between #2 and #3. There must be at least 16 weeks between #1 and #3. |
| **MMR** (Measels, Mumps & Rubella) Or individual vaccines or titers | MMR: #1\_\_\_\_\_\_\_\_\_\_ 2#\_\_\_\_\_\_\_\_\_  Measles: #1\_\_\_\_\_\_\_\_\_\_ 2#\_\_\_\_\_\_\_\_\_  Mumps #1\_\_\_\_\_\_\_\_\_\_ 2#\_\_\_\_\_\_\_\_\_  Rubella #1\_\_\_\_\_\_\_\_\_\_ 2#\_\_\_\_\_\_\_\_\_  Or Positive Titer Date: \_\_\_\_\_\_\_\_\_\_\_ | Dose #1: Must be given on or after the 1st birthday  Dose #2: Must be given greater than or equal to 28 days after the first dose or laboratory evidence of immunity is acceptable. |
| **Varicella Vaccination**  Laboratory evidence for immunity is acceptable in lieu of immunization or history of chicken pox. | Varicella #1\_\_\_\_\_\_\_\_\_\_ 2#\_\_\_\_\_\_\_\_\_  Or Positive Titer Date: \_\_\_\_\_\_\_\_\_\_\_  History of Disease:  Age: \_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_ | Dose #1: on or after the first birthday.  Dose #2: at least 28 days after dose #1.  Medical record documentation signed by the provider required for a history of chickenpox or laboratory evidence of immunity is acceptable. |
| **TDAP** (Tetanus, Diphtheria, Pertussis) | TDAP \_\_\_\_\_\_\_\_\_ \*  Td: \_\_\_\_\_\_\_\_\_ | Tdap must have been given at or after the age of 7.  \*If Tdap was given before 2013 (greater than or equal to 10 years ago), you must also provide a current Td or Tdap. |
| **Meningococcal Quadrivalent** (Meningitis A, C, W, Y)  Required of students 21 years of age and younger. | #1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Menactra Menveo | 1 Dose of MenACWY (formerly MCV4) on or after age 16 or a signed waiver. |
| **Meningococcal Group B**  (Bexsero or Trumenba) | Bexsero #1\_\_\_\_\_\_\_\_\_ 2# \_\_\_\_\_\_\_\_\_\_  Trumenba #1\_\_\_\_\_\_\_\_\_ 2#\_\_\_\_\_\_\_\_\_\_ | Besxero: 2 doses, second dose at least 1 month after the first dose.  Trumenba: 2 or 3 doses, for those not at risk, 2 doses, second dose 6 months after the first dose. Those with increased risk 3 doses. Second dose 1-2 months after first dose. Third dose 6 months after the first. |
| **TB Skin Test/Quantiferon Gold/ Low Risk Testing Not Indicated** | Skin Test:  Date: \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_mm  Or/ Quantiferon Gold Blood Test  Positive Negative  Or/ Low Risk Testing Not Indicated  Yes No | If TB Skin test or QuantiFERON Gold test produces positive results, a subsequent chest X-Ray will be required. |

*Please complete information on next page*



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| **Strongly Recommended/Additional Immunizations (mm/dd/yyyy)** | | |
| Covid-19 Vaccine & Booster | Vaccine Manufacturer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Dose #1: \_\_\_\_\_\_\_\_\_ Dose 2# \_\_\_\_\_\_\_\_\_  Booster Manufacturer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Most recent booster: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Accepted Vaccines:  Pfizer-BioNTech/Moderna/Johnson&Johnson's Janssen/WHO Approved List |
| Gardasil (HPV) Humna Papillomavirus | #1 \_\_\_\_\_\_\_ #2 \_\_\_\_\_\_\_\_\_ #3 \_\_\_\_\_\_\_\_\_ | 3 doses over 6 months |
| Hepatitis A | #1 \_\_\_\_\_\_\_ #2 \_\_\_\_\_\_\_\_\_ | 2 doses at least 6 months apart |
| Typhoid | Date: \_\_\_\_\_\_\_\_\_\_ |  |
| Yellow Fever | Date: \_\_\_\_\_\_\_\_\_\_ |  |
| BCG | Date: \_\_\_\_\_\_\_\_\_\_ |  |