DRAKE UNIVERSITY
COLLEGE OF PHARMACY & HEALTH SCIENCES
EXPERIENTIAL PHARMACY EDUCATION PROGRAM

Immunization Record

All students are required to provide documentation to the college and to the hospital sites of current immunization as follows:
Acceptable documentation is a physician record or immunization card or laboratory copies of titres

1) Measles/Mumps/Rubella
   - Measles - **Two Dates Needed-** or positive lab titre
   - Mumps – **Two Dates Needed**-or positive lab titre
   - Rubella – **Two Dates Needed**-or positive lab titre
2) Tetanus/Diphtheria (Td) or Tetanus/Diphtheria/acellular pertussis (Tdap) - Must show proof **within last 10 years**
3) Tuberculosis (PPD) test- Proof **within last 3 months** (valid for 1 year from date of test while on rotations)-if documented Positive TB test in the past, annual TB questionnaire completed is required.
4) Hepatitis B – Proof of series of three vaccines or blood (laboratory titres) work showing immunity is required
5) Varicella (Chicken Pox)- Reliable history of disease, vaccine or blood work (lab titres) showing immunity is required

Students, please provide the information requested below, return one copy to the Director of Experiential Education Programs, and retain a copy for your records to verify immunizations if requested by rotation sites.

NAME:_____ Date of Birth:_____
Last First Banner ID # _____

Please indicate the following dates:

Td _____ (or) **Tdap** _____ **Hepatitis B** **1.**_____

Measles (#1)_____ (#2)_____ **2.**_____

Mumps (#1) _____ (#2)_____ **3.**_____

Rubella (#1) _____ (#2)_____

Chicken Pox ☐ Disease ☐ Vaccine 1._____ 2._____ ☐ Titre date/result _____

Health Care Provider _____ Date _____

PPD Tuberculin test

*Date Given*_____ *Date Read*_____ *Induration in mm*_____ Signature _____

*Date Given*_____ *Date Read*_____ *Induration in mm*_____ Signature _____

*Date Given*_____ *Date Read*_____ *Induration in mm*_____ Signature _____

*Date Given*_____ *Date Read*_____ *Induration in mm*_____ Signature _____

If you have a positive TB test, you must be evaluated by a health care provider. Please indicate below results of the chest x-ray and a treatment plan if indicated. (Did the health care provider start you on medication?)

Date of CXR _____ results _____

Treatment: _____ signature_____

TB positive annual follow up

Date annual questionnaire completed / no symptoms of disease _____Signature_____

Date annual questionnaire completed/no symptoms of disease_____ Signature_____

Date annual questionnaire completed/no symptoms of disease_____Signature_____

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(515) 271-3731 FAX (515) 271-1855

White-Health Center Yellow-Student Pink-Pharmacy