MUHLENBERG COLLEGE HEALTH SERVICES
PREADMISSION IMMUNIZATION POLICY

Student’s Name: ___________________________ DOB: ______________

All incoming freshman, transfer, and foreign exchange students are required to have the following
immunizations completed according to these requirements before matriculating to Muhlenberg College.

Measles, Mumps, Rubella (MMR): Students born after 1956 are required to have two doses of MMR vaccine at least 28 days apart after 12 months of age. Laboratory evidence of immunity is acceptable. History of disease is not accepted.

Tetanus/Diphtheria: Completion of the primary series of DPT, DT, Td, and booster dose within past 10 years.

Hepatitis B: Begun or completed hepatitis B vaccine 3 dose series. Laboratory evidence of immunity is acceptable.

Varicella: 2 properly spaced doses of varicella vaccine, laboratory evidence of immunity, or history of varicella.

Meningococcal: All students who are residing in college-owned housing are required to have at least one dose of the meningococcal vaccine or a signed waiver declining the vaccine after being given literature on the vaccine and the disease.

EXEMPTIONS: Exemption to any of the immunization requirements can be granted to students who provide a note or letter signed by a licensed physician stating the medical reason why the student should not or need not receive the vaccine, or, a statement signed by the student or by the parent/guardian if the student is less than 18 years of age, that the immunization(s) is against his or her personal beliefs.

IMMUNIZATION RECORD -Please list all dates including month, day, and year

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Dose 1</th>
<th>Dose 2</th>
<th>Dose 3</th>
<th>Dose 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMR</td>
<td><strong>/</strong>/__</td>
<td><strong>/</strong>/__</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DTP</td>
<td><strong>/</strong>/__</td>
<td><strong>/</strong>/__</td>
<td><strong>/</strong>/__</td>
<td><strong>/</strong>/__</td>
</tr>
<tr>
<td>Td or Tdap</td>
<td>(Please circle type of booster given within 10 years) Date <strong>/</strong>/__</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OPV/IPV</td>
<td><strong>/</strong>/__</td>
<td><strong>/</strong>/__</td>
<td><strong>/</strong>/__</td>
<td><strong>/</strong>/__</td>
</tr>
<tr>
<td>VARICELLA</td>
<td><strong>/</strong>/__</td>
<td><strong>/</strong>/__</td>
<td>or Varicella Disease <strong>/</strong>/__</td>
<td></td>
</tr>
<tr>
<td>HEPATITIS B</td>
<td><strong>/</strong>/__</td>
<td><strong>/</strong>/__</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MENINGOCOCCAL Dose 1 __/__/__

Extracted from the Pennsylvania Department of Health Bureau of Communicable Diseases- Division of Immunizations (9/2002)

Tuberculosis Screening is required of all high-risk students within 6 months prior to college entrance.

*CATEGORIES OF HIGH RISK STUDENTS FOR TB SCREENING:

- Those who have arrived within the past 5 years from countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Therefore, students should undergo TB screening if they have arrived from countries EXCEPT those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia, USA, Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, or New Zealand.

- Those with HIV infection, who inject drugs, who have resided in, volunteered in, or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters

- Those who have clinical conditions, such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunal bypass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g., prednisone 15 mg/d for one month) or other immunosuppressive disorders

Adapted from the American College of Health Vaccine Preventable Diseases Committee (August 2006)

HEALTH CARE PRACTITIONER SIGNATURE: ___________________________ DATE: ______________

HEALTH CARE PRACTITIONER PRINTED NAME ______________________________________________