PENNSTATE HERSHEY
Milton S. Hershey Medical Center

Penn State Milton S. Hershey Medical Center
Employee Health Department
500 University Drive, H087
Hershey, PA 17033
Telephone (717) 531-8280 Fax (717) 531-3966

Employee Health Department
REQUIREMENTS

PLEASE READ AND FOLLOW THESE INSTRUCTIONS CAREFULLY!

Complete the Infectious Disease Summary and provide **official supporting documentation** of the following:

- Documentation of MMR I and II (date) OR documentation of positive Rubella, Rubeola, and Mumps titers (blood test)
- Documentation of 2 Varicella immunizations OR documentation of a positive Varicella titer (blood test)
- Date and result of any TB skin tests received within the past 2 years
- Date of last Tdap (Tetanus, Diptheria, Pertussis) vaccination
- Documentation of the Hepatitis B immunization series

NOTE: The immunization information may be obtained from your health care provider's office. Information must be received by Employee Health at orientation. If not submitted you will be required to have blood work drawn at the employee health initial health screen.

*By regulation, employee health records and your personal medical records are maintained separately.

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Employee Health Department
INFECTIOUS DISEASE SUMMARY

*****Complete the Infectious Disease Summary AND provide official supporting documentation of immunizations from your medical provider and/or healthcare institution**

Name: _____

Address: _____

Phone Number _____

City: _____ **State:** _____

Date of Birth: ____/____/____

Zip Code: _____

Department_____ **Job Title**_____

Emergency Contact_____

Phone Number_____

TUBERCULOSIS STATUS: (Most recent)

TB Skin Test
Administered ___/____/____ Read ____/____/____
Results: Negative_____
Positive_____ mm

TB Skin Test
Administered ___/____/____ Read ____/____/____
Results: Negative_____
Positive_____ mm

IF HISTORY OF POSITIVE TB TEST
Provide copy of most recent Chest X-ray report and provide any additional medical treatment received.

MMR Status:

Two Doses of Vaccine
(1) ____/____/____
(2) ____/____/____
OR
Positive Antibody Titer by Lab Screen
Rubella Date: ____/____/____
Rubeola Date: ____/____/____
Mumps Date: ____/____/____

If any of the Titers are Negative Vaccination is needed

IMMUNIZATIONS:

Tetanus, Diphtheria, Pertussis (TDAP)
Date: ____/____/____

Hepatitis B - Dates
(1) ____/____/____
(2) ____/____/____
(3) ____/____/____

(Optional) Hepatitis B titer
Date/Result_____

Varicella (Chicken Pox)

Two Doses of Vaccine
(1) ____/____/____
(2) ____/____/____
OR
Positive Antibody Titer by Lab Screen
Date: ____/____/____

History of Varicella is not accepted

Signature of Medical Provider: _____ **Date:** ____/____/____

Address: _____ **City:** _____**State:**_____ **Zip Code:** _____

Signature of Employee_____ **Date**____/____/____