HARCUM
HARCUM COLLEGE

Department of Student Life
Harcum Health Center
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Bryn Mawr, PA 19010

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NAME:_____
LAST FIRST
DOB:_____/_____/_____

TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER
COPY OF LAB REPORTS REQUIRED

TUBERCULIN SKIN TEST (PPD)
Two-step PPD required

DATE PLACED: _____DATE PLACED_____
DATE READ: _____ DATE READ;_____
RESULT: positive / negative RESULT: positive / negative
If *POSITIVE*, Chest X-Ray Required. Attach copy of report.

MEASLES TITER (Blood test)

DATE: _____
RESULT: positive / negative (PLEASE CIRCLE)
BOOSTER DATE: _____

MUMPS TITER (Blood test)

DATE: _____
RESULT: positive / negative (PLEASE CIRCLE)
BOOSTER DATE: _____

RUBELLA TITER (Blood test)

DATE: _____
RESULT: positive / negative (PLEASE CIRCLE)
BOOSTER DATE: _____

VARICELLA TITER (Blood test)

DATE: _____
RESULT: Reactive / non-reactive (PLEASE CIRCLE)
BOOSTER DATE (2 Doses Required):
#1_____ #2_____

HEPATITIS B SURFACE AB (Blood test)

DATE: _____
RESULT: Reactive / non-reactive (PLEASE CIRCLE)

If non-reactive repeat series HEPATITIS B VACCINE SERIES #1_____ #2_____#3_____

MEDICAL PROVIDER'S SIGNATURE_____ DATE _____

ADDRESS AND PHONE _____

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