Barry University

American DataBank

Physician Assistant Initial Immunization Record Form

INSTRUCTIONS

Before you create your account with Barry University Physician Assistant Immunization Tracking System, please be aware that your yearly subscription fee for using the Tracking System is $30.00. You will need your Credit Card to pay this subscription fee.

Instructions for creating your Immunization Account on the Immunization Tracking System (ITS)

1. Go to www.barryPA.com and click 'Immunization Tracking System'
2. Read the instructions on this page, and download the necessary forms
3. Click 'Login to the Immunization Tracking System' on the bottom of the page to get to the ITS
4. Create your account by clicking "Online Registration" and fill out all of the necessary information.
5. Process your payment by submitting Credit Card information.
6. You can now login to the ITS, enter your immunization information into the ITS for verification
7. After entering the dates, send all necessary forms and documents to American DataBank by scanning and uploading the documents directly into your ITS Profile
8. Check back in your account in 24-48 hours to see your updated status

Instructions for entering your Requirements on the Immunization Tracking System

1. Tdap: Within last 10 Years

You must have a Tdap within last 10 years, or show proof of a Td AND separate Pertussis Vaccination (within the last 10 years). Please enter the date of your Tdap (or Td and Pertussis) vaccination on this Form and in the Tracking System.

2. Varicella (Chicken Pox)

You must have proof of ONE of the following:

a) 2 doses of the Varicella Vaccine
b) Proof of Natural Varicella (Chicken Pox) Disease.
c) Varicella Blood Test, with presence of IgG antibody by either Latex Agglutination or ELISA (preferable) testing. Any students not showing past exposure, or a positive test result, must have the two Varicella Vaccinations which are 4-8 weeks apart. **Official labwork printout is required for this option.**

Please enter the Vaccine date, OR Varicella Blood Test date with result, OR the Natural Varicella Disease date on this Form and in the Tracking System.

3. Hepatitis B

You must have a Hepatitis B Surface Antibody Blood Test (HBsAb) with "Positive (POS) or Negative (NEG)" result to be compliant. If your Hepatitis B testing is not-immune (Negative/Equivocal) you must repeat a 3 shot series for Hepatitis B, and then re-test for HBsAb. Please enter your Hepatitis B Test date, and any necessary vaccinations on this Form and in the Tracking System. **Official labwork printout is required for this option.**

4. Measles (Rubeola), Mumps, and Rubella

You must have proof of ONE of the following:

a) 2 doses of Measles, Mumps, and Rubella Vaccines
b) Measles, Mumps and Rubella IGG Bloodwork showing immunity. If you show as Not-Reactive, Negative Immunity, you must show proof of a complete MMR Series. **Official labwork printout is required for this option.**
c) Documented dates of disease for Measles, Mumps and Rubella.

Please enter the date of the vaccinations, diseases or titers. Official documentation required for the blood-work, if completed.

5. PPD: Annual

You must have a PPD every 12 months. If the PPD is Negative, you are required to have Annual PPD. Please enter the date and Negative result on this Form and in the Tracking System.

If a PPD is Positive, you will need a Chest X-Ray with a Negative result (One Time) to be compliant. Please enter your Positive PPD date, Chest X-Ray date, and result on the Form and in the Tracking System.

Quantiferon Test: this test is acceptable but **not the preferred** testing method. **Test must be completed annually**. Indicate the date received. Please note this testing method has a one-two week turnaround time. If using this option, please **contact your program director**.

If you received the BCG vaccination in the past, please submit documentation for that vaccination (One Time). See your healthcare provider for further steps in relation to your TB Infection/Exposure Status. Enter the date of your vaccination on the form and into the Tracking System.

6. Statement of Good Health: Annual

You must present the Statement of Good Health. This should not include any other student health information and should not include a physical examination; it should attest to the student's good health and state that the student may enroll in the Program without restrictions. Please fill out Page 3 and sign the form. **Also make sure to upload the signed Statement of Good Health Form to American DataBank.**

7. Student Health Insurance: Annual

You must present proof of current Health Insurance Coverage. This can be either Barry U Health Insurance, proven by enrollment form, receipt of payment, or insurance card. OR, you can decline Barry U coverage, turning in the Insurance Waiver Form AND a copy of the front and back of your insurance card. See www.barrypa.com for the Waiver Form. **Note: Be sure to renew early, as Students may not have a lapse in coverage.**

8. American Heart Association BLS CPR Card: Renew When Expired

First Year Barry students must have a BLS Certification valid for the entire didactic year (August-July). See www.heart.org for more information on the AHA BLS for Healthcare Providers CPR Certification. A copy of the front and back of your current CPR Card should be submitted to ADB.

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Physician Assistant Initial Immunization Record Form

I hereby certify that the certification information below is true and correct to the best of my knowledge and abilities, and willingly release it to Barry University, American DataBank, and any and all clinical sites for the purpose of my education and clinical experiences. This information will not be disseminated for any other purpose than that specified by the applicant. By affixing my signature, I grant my full consent for the duration of my enrollment at Barry. I am aware that I can revoke my consent, in writing, at any time.

Student Name (Print): _____ **Date:** _____ (M) _____ (D) _____(Y)

Student Signature: _____ **Student ID:** _____

*****Student MUST scan and upload documents to their ITS Profile. *****

Program of Study: ☐ Physician Assistant | **Campus:** ☐ Miami Shores ☐ St. Croix ☐ St. Petersburg | **Grade Level:** ☐ Clinical (2nd) ☐ Didactic (1st) ☐ Adv. Didactic (3rd)

Immunization Requirements: Initial Form

Tdap (Tetanus Diphtheria and Acellular Pertussis) — **Required Within last Ten Years**

A	**Tdap Vaccination Date:** _____(M) _____(D) _____(Y)	
B	**Td Vaccination Date:** _____(M) _____(D) _____(Y)	**If you have an allergy to TT or Td Pertussis Vaccination Date: ____ M ____ D ____ Y**

Varicella (Chickenpox) — **Required One Time**

A	**Proof of Natural Varicella (Chicken Pox) Disease Date:** _____(M) _____(D) _____(Y)	
B	**Varicella Dose 1:** _____(M) _____(D) _____(Y)	**Varicella Dose 2:** _____(M) _____(D) _____(Y)
C	**Varicella Presence of IgG Antibody Date:** _____(M) _____(D) _____(Y)	**◀ MUST SEND LABWORK PRINTOUT**

Hepatitis B — **Required One Time**

HepB 1st Shot Date: ____(M) ____(D) ____(Y) | **HepB 2nd Shot Date:** ____(M) _____(D) ____(Y) | **HepB 3rd Shot Date:** ____(M) ____(D) ____(Y)

Required > **Hepatitis B (Anti-HBsAg) Test Date:** _____(M) _____(D) _____(Y) ☐ POS or ☐ NEG — **◀ MUST SEND LABWORK PRINTOUT**

If Non-responder, repeat shots and re-test as shown below:
for the Antibody, Repeat Shots and Re-Test

HepB 4th Shot Date: ____(M) ____(D) ____(Y) | **HepB 5th Shot Date:** ____(M) _____(D) ____(Y) | **HepB 6th Shot Date:** ____(M) ____(D) ____(Y)

Hepatitis B (Anti-HBsAg) Date: _____(M) _____(D) _____(Y) ☐ POS or ☐ NEG — **◀ MUST SEND LABWORK PRINTOUT**

MMR (Measles, Mumps and Rubella) — **Required One Time**

A	**MMR Dose 1:** _____(M) _____(D) _____(Y)	**MMR Dose 2:** _____(M) _____(D) _____(Y)
B	**Measles Immune IgG Date:** _____(M) _____(D) _____(Y) ☐ POS or ☐ NEG	
	Mumps Immune IgG Date: _____(M) _____(D) _____(Y) ☐ POS or ☐ NEG	
	Rubella Immune IgG Date: _____(M) _____(D) _____(Y) ☐ POS or ☐ NEG	
C	**Measles Date of Disease:** _____(M) _____(D) _____(Y)	**◀ MUST SEND LABWORK PRINTOUT**
	Mumps Date of Disease: _____(M) _____(D) _____(Y)	
	Rubella Date of Disease: _____(M) _____(D) _____(Y)	

PPD (Tuberculosis Testing) — **Required Every Year**

A	**PPD (ANNUAL) :** _____(M) _____(D) _____(Y)	**Result:** ☐ Positive or ☐ Negative
B	**Chest X-Ray (ONE TIME) Date:** _____(M) _____(D) _____(Y)	**Chest X-Ray Result:** ☐ Positive or ☐ Negative
C	**Have you received the BCG Vaccination? If so, indicate the date:** _____(M) _____(D) _____(Y)	
	Have you received the Quantiferon Test? If so, indicate the date: _____(M) _____(D) _____(Y) **(COMPLETE ANNUALLY)**	

Physician/Healthcare Provider Signature: _____ **Signature Date:** _____

Physician/Healthcare Provider Stamp:

Barry University
Physician Assistant Program

Student Statement of Good Health

Name_____ **Phone:**_____

Student or SS # _____ **Birthdate:**_____

This form is to be completed by a medical doctor or licensed practitioner and uploaded to your American DataBank ITS Account.

Statement of Good Health:

I have examined the above named student who appears to be in good health and who may enroll in the Physician Assistant Program without restrictions.

Health Care Provider (Please sign and place health care provider address and phone number or stamp below).

Name of Provider _____ **Signature**_____ **Date**_____

Address _____

_____

_____

Phone _____