Pennsylvania College of Technology
A Penn State Affiliate

Mandatory: Immunization Verification Form

College Health Services • 570.320.5234 • 570.329.4947 (fax)

PART I: Completed by student. Please print.

Student _____
Last name *First name* *Date of birth*

_____
ID number *Cell/home phone*

I hereby authorize, and give my consent to, the medical provider completing this form to release the information herein to Penn College College Health Services.

Student signature _____ Date_____/_____/_____
MM *DD* *YYYY*

Upload completed form and supporting documentation to MyHealth Online at pct.medicatconnect.com (use Penn College network username and password).

PART II: To be completed and signed by your healthcare provider. *All information must be in English.*
Required for all students.

1. Meningococcal Conjugate (MCV4) *Students requesting a waiver must provide written notification via the Meningitis Waiver Form.*

One dose (on or after 16th birthday) _____/_____/_____ Specify type (e.g., Menactra) _____
MM *DD* *YYYY*

2. MMR (Measles, Mumps, Rubella)

Dose #1 _____/_____/_____ Dose #2 _____/_____/_____
MM *DD* *YYYY* *MM* *DD* *YYYY*

3. Tetanus *Must be within the last 10 years.*

Tdap (Adacel/Boostrix) _____/_____/_____ **or** Td _____/_____/_____
MM *DD* *YYYY* *MM* *DD* *YYYY*

4. Hepatitis B

Dose #1 _____/_____/_____ Dose #2 _____/_____/_____ Dose #3 _____/_____/_____
MM *DD* *YYYY* *MM* *DD* *YYYY* *MM* *DD* *YYYY*

5. Varicella

1. History of disease ☐ Yes ☐ No

2. Immunization Dose #1 _____/_____/_____ Dose #2 _____/_____/_____
MM *DD* *YYYY* *MM* *DD* *YYYY*

6. Meningococcal Serougroup B (Two or three dose series)

MenB-RC (Bexsero)

Dose #1 _____/_____/_____ Dose #2 _____/_____/_____
MM *DD* *YYYY* *MM* *DD* *YYYY*

or

MenB-FHbp (Trumenba)

Dose #1 _____/_____/_____ Dose #2 _____/_____/_____ Dose #3 _____/_____/_____
MM *DD* *YYYY* *MM* *DD* *YYYY* *MM* *DD* *YYYY*

HEALTHCARE PROVIDER: Provide this completed form and a copy of any immunization records to the student.

_____
Name (print)

_____
Medical provider signature

_____
Office phone number

Office stamp or address

PC 1952 7/19