

STEP 1: 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 the College Health Portal at pct.studenthealthportal.com
(use Penn College network username and password).

You will receive Secure Messages through the College Health Portal. Look for the following:

Secure Message From Penn College Health Services

P Penn College Health Portal <noreply@studenthealthportal.com>

To: Hello student,

You have received a new Secure Message via the Penn College Health Portal. Please [click here](#) to retrieve your message.

Thank you,

Penn College Health Services

570-320-5234

STEP 2: You must attach immunization documentation/records that include your name and date of birth OR provide an office stamp/signature from your medical provider in the space provided

IMMUNIZATION DOCUMENTATION/RECORDS MAY BE OBTAINED FROM YOUR FAMILY DOCTOR, HIGH SCHOOL OR THE HEALTH DEPARTMENT ** If vaccine dates are not available, positive serological titers (blood work) may also be sent as proof of vaccination.

HEALTHCARE PROVIDER NOTE: If immunization records are not being attached, please complete the signature section and add the student's vaccine dates to the chart below

Name (print) _____

Medical provider signature

Office phone number

Office Stamp or Address

Required vaccines for all students	1 st DOSE DATE	2 nd DOSE DATE	3 rd DOSE DATE	4 th DOSE DATE
Hepatitis B Minimum three (3) shot series is required				
Meningitis – Serogroup A,C,Y, W135 (Menactra, Menveo, Menomune) Must be at least one (1) dose given on or after age 16. (Students age 23 or older are exempt from this vaccine.) **Students age 22 or below MUST provide proof of this immunization before moving on campus**				
MMR OR MMRV – Two (2) doses given 28 days apart (Measles/Mumps/Rubella) OR (Measles/Mumps/Rubella/Varicella)				
TDAP OR Td Tetanus vaccine administered within the last 10 years				
Varicella (chicken pox) OR MMRV – Two (2) doses given 28 days apart (Varicella) OR (Measles/Mumps/Rubella/Varicella) OR history of disease			Year/Age had chicken pox:	
Recommended vaccines for students below age 23 (not required)	1st DOSE DATE	2nd DOSE DATE	3rd DOSE DATE	4th DOSE DATE
Meningococcal Serogroup B – Two (2) doses				

Please Note: Students may have additional or different clinical requirements upon acceptance into Nursing & Health Science (NHS) programs.



This form must be completed by your medical provider.

Completed by student. Please print. Upload completed form and supporting documentation to College Health Portal.

Student _____
Last name First name Date of birth

Penn College ID number Cell/home phone

I hereby authorize, and give my consent to, the medical provider completing the immunization/physical exam form to release the information herein to Penn College's College Health Services, Workforce Development's Paramedic Program at Penn College, and to my clinical sites for evaluation and clearance to participate in my clinical experiences.

Student signature _____ Date ____/____/____
mm dd yyyy

1. Immunization Records – *Attach completed College Health Services Immunization Verification form.*

2. COVID-19 Vaccination*

_____ 1st dose _____ 2nd dose _____ booster (optional)
_____ Manufacturer _____ Manufacturer _____ Manufacturer

*Students enrolled in the Paramedic Program should be aware that the COVID-19 vaccination may be required to participate in clinical experiences. Failure to complete any requirement(s) by established deadlines may impact progression in and completion of the program.

3. Evidence of vaccination or lab reports demonstrating positive titers for the following mandatory vaccinations. *Students who submit titers in lieu of vaccines will be required to obtain vaccine(s) for any titer(s) returning a negative result.*

- ☐ CPT code: **86765** – Measles Antibody (Rubeola), IgG, Serum
☐ CPT code: **86735** – Mumps Virus Antibody, IgG, Serum
☐ CPT code: **86762** – Rubella Antibody, IgG, Quantitative, Serum
☐ CPT code: **86706** – Hepatitis B Surface Antibody (HBSAB), Plasma/Serum
☐ CPT code: **86787** – Varicella-Zoster Virus Antibody, IgG, Serum

4. Two-Step PPD** – *T-SPOT and QuantiFERON-TB Gold are not acceptable.*

1st PPD				2nd PPD			
Placed	____/____/____	time	☐ AM ☐ PM	Placed***	____/____/____	time	☐ AM ☐ PM
	mm dd yyyy				mm dd yyyy		
Read	____/____/____	time	☐ AM ☐ PM	Read	____/____/____	time	☐ AM ☐ PM
	mm dd yyyy				mm dd yyyy		
Results	_____ mm			Results	_____ mm		

**Must be two-step PPD completed within the last 30 days.

***Must be placed 7-21 days after read date of 1st negative PPD.

History of BCG or positive PPD/TB requires an annual chest X-ray. (Attach results) Date of X-ray: ____/____/____
mm dd yyyy

5. Physical Exam/Medical Provider Statement – I have completed a physical examination of the individual named above and, to the best of my knowledge, they are in good physical and mental health, free of any communicable diseases, and is able to function in the clinical setting at full capacity.

Date of exam

Office phone number

Name (print)

Medical provider signature

Office stamp or address