PENN COLLEGE HEALTH SERVICES

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IMMUNIZATION VERIFICATION FORM

Upload the completed Immunization Verification Form and all other related documents through myHealth Online at pct.medicatconnect.com.

PART I

Name _____
First Name Middle Name Last Name

_____
Street Address City State Zip

Date of Birth ____/____/_____ PCT ID# _____

Status: Part-time _____ Full-time _____

PART II: TO BE COMPLETED AND SIGNED BY YOUR MEDICAL PROVIDER. ***All information must be in English.***

REQUIRED VACCINATION FOR ON-CAMPUS STUDENTS/STRONGLY RECOMMENDED FOR ALL STUDENTS. ***Students who request a waiver for this vaccination must provide written notification via the Meningitis Waiver Form.***

A. MENINGOCOCCAL QUADRIVALENT

(A, C, Y, W-135) One or 2 doses for all college students; revaccinate every 5 years.

1. Quadrivalent conjugate

a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____
M D Y M D Y

REQUIRED VACCINATIONS FOR ALL STUDENTS

A. MMR (MEASLES, MUMPS, RUBELLA)

a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____
M D Y M D Y

B. TETANUS, DIPHTHERIA, PERTUSSIS *Tdap booster must be within the last 10 years*

1. Primary series completed? Yes ___ No ___ Date of last dose in series: ____/____/_____
M D Y

2. Date of most recent booster dose: ____/____/_____ Type of booster: Td _____ Tdap _____
M D Y

C. HEPATITIS B

a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____ c. Dose #3 ____/____/_____
M D Y M D Y M D Y

D. VARICELLA

1. History of Disease Yes ___ No ___

2. Immunization

a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____
M D Y M D Y

STRONGLY RECOMMENDED VACCINATIONS FOR ALL STUDENTS

A. INFLUENZA

Date of last dose: ____/____/_____
M D Y

B. HUMAN PAPILLOMAVIRUS VACCINE (HPV2/HPV4/HPV9)

a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____ c. Dose #3 ____/____/_____
M D Y M D Y M D Y

C. HEPATITIS A

a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____
M D Y M D Y

D. MENINGOCOCCAL SEROUGROUP B (Two or three dose series)

1. MenB-RC (Bexsero) __ routine ____outbreak –related

a. Dose #1____/____/_____ b. Dose #2. ____/____/_____
M D Y M D Y

OR

1. MenB-FHbp (Trumenba) __routine ___outbreak-related

a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____ c. Dose #3 ____/____/_____
M D Y M D Y M D Y

MEDICAL PROVIDER

Name _____ Signature _____

Address _____ Phone (_____) _____

PROVIDER: Provide this completed form and a copy of any immunizations to the student.