Dickinson Wellness Center

Last Name, First Name _____ Date of Birth _____

Immunization Record Form

- All information must be provided in English.
- Healthcare provider must complete and sign the immunization record form or submit a copy of the student's immunization record.
- Statements such as "received as a child", "records not available", or "up to date" ***ARE NOT ACCEPTABLE.***

REQUIRED IMMUNIZATIONS	DATES (Month/Day/Year)	PENNSYLVANIA STATE REQUIREMENTS
MMR	#1 ___/___/___ #2 ___/___/___	2 doses of MMR (measles,mumps, and rubella), single component vaccines or positive titers. Minimum of 4 weeks between doses. **1st vaccine dose cannot be given before 1st birthday.**
OR		
	Measles #1 ___/___/___ #2 ___/___/___	
	Mumps #1 ___/___/___ #2 ___/___/___	
	Rubella #1 ___/___/___ #2 ___/___/___	
OR		
Positive Titer	Measles ___/___/___ Mumps ___/___/___ **ATTACH LAB** Rubella ___/___/___ **REPORT**	
Tdap	Adult Tdap ___/___/___ (Adacel or Boostrix)	Tetanus, Diphtheria, Pertussis vaccine in the past 10 years. Tetanus/Diphtheria only vaccine **is not acceptable.**
Meningitis (quadrivalent)	Menactra or Menveo ___/___/___ Booster (if indicated) ___/___/___	Meningitis A,C,Y,W-135 vaccine after the age of 16. **All students must provide proof of immunization or sign a waiver declining the meningitis vaccine in order to be housed on campus.**
OR		
	Meningitis Waiver (click on link to download and sign)	
Hepatitis B Series	#1 ___/___/___ #2 ___/___/___ #3 ___/___/___ ❒ pediatric dose or ❒ adult dose	Series of 3 age appropriate doses (given at 0, 1-2 mo., and 6-12 mo.) at any age. Adolescents age 11-15 years can be given 2 adult doses (given at 0, and 4-6 mo)
OR		
Hepatitis B Titer	Hepatitis B Surface Antibody ___/___/___ **ATTACH LAB REPORT**	
Varicella	#1 ___/___/___ #2 ___/___/___	Health care provider documentation of immunization, history of disease, or positive titer.
OR		
	Date of Disease ___/___/___	2 doses of vaccine **at least 12 weeks apart if between the age of 1 and 12 years.**
OR		
	Positive Titer Date ___/___/___ **ATTACH LAB REPORT**	2 doses of vaccine **at least 4 weeks apart if between the age 13 years or older.**

HIGHLY RECOMMENDED VACCINES

Hepatitis A Vaccine	#1 ___/___/___	#2 ___/___/___		
HPV Vaccine	#1 ___/___/___	#2 ___/___/___	#3 ___/___/___	
Meningitis B Vaccine	Bexsero or Trumemba #1 ___/___/___	#2 ___/___/___	#3 ___/___/___(Trumemba)	

Healthcare Provider Name or Office Stamp:

_____ _____ ___/___/___

Print Name *Signature* *Date*