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 IMMUNIZATION	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 ___/___/___ Rubella ___/___/___ **ATTACH LAB 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 ___/___/___	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. 2 doses of vaccine **at least 12 weeks apart** if given at age 1-12 years. 2 doses of vaccine **at least 4 weeks apart** if given at age 13 or older.
OR	Date of Disease ___/___/___	
OR	Positive Titer Date ___/___/___ **ATTACH LAB REPORT**	

eks
2.

HIGHLY RECOMMENDED VACCINES

COVID-19 Vaccine	#1 ___/___/___ #2 ___/___/___ ___/___/___ (Booster) #1 ___/___/___ ___/___/___ (Booster) #1 ___/___/___	Monovalent ❒ Pfizer ❒ Moderna ❒ J&J Bivalent ❒ Pfizer ❒ Moderna
Hepatitis A Vaccine	#1 ___/___/___ #2 ___/___/___	
HPV Vaccine	#1 ___/___/___ #2 ___/___/___ #3 ___/___/___	
Meningitis B Vaccine	Bexsero or Trumemba #1 ___/___/___ #2 ___/___/___ #3 ___/___/___(Trumemba)	

Health Care Provider Signature or Office Stamp:

Print Name ______________________________

Signature ______________________ **Date** ___/___/___