



Bailey Health Center

IMMUNIZATION RECORD

Last Name, First Name: _____ L#: _____

Date of Birth: ____/____/____ Date of Entry: ____/____/____ Cell: (____) ____-____
M D Y M Y

THIS FORM MUST BE COMPLETED & SIGNED BY YOUR HEALTH CARE PROVIDER. ONCE COMPLETE FORMS CAN BE UPLOADED ONTO YOUR CHART USING THE UPLOAD OPTION ON THE STUDENT HEALTH PORTAL.

Pennsylvania State Law requires that all students residing in college owned housing be vaccinated against meningitis.

1. Meningococcal Tetravalent (MCV4) **Required** at least one dose **AFTER** the 16th birthday.
Dose #1 ____/____/____ Dose #2 (after the age of 16) ____/____/____
2. Meningococcal Group B (Bexsero or Trumemba) **Strongly recommended**, several recent outbreaks of serogroup B meningitis on college campuses in this region highlight the importance of vaccinating for this deadly strain of meningitis. ***This strain of meningitis is not covered by the traditional meningitis vaccine.***
Dose #1 ____/____/____ Dose#2 ____/____/____
Trumemba or Bexsero Trumemba or Bexsero

Many health care providers do not have the meningococcal group B vaccine. Trumenba will be available at the Bailey Health Center.

M.M.R. (Measles, Mumps, Rubella)
Required

1. Dose 1 given at age 12 months or later.....#1 ____/____/____
M D Y
2. Dose 2 given at least 28 days after first dose #2 ____/____/____
M D Y

Strongly Recommended
A third dose of MMR is strongly recommended because of several recent outbreaks of mumps on college campuses. Students previously vaccinated with 2 doses of MMR during childhood were not protected during these outbreaks. The Advisory Committee on Immunization Practices (ACIP) reviewed evidence and determined the third dose to be safe and effective.

3. Dose 3.....#3 ____/____/____
M D Y

POLIO
Required
Dose #1 ____/____/____ Dose#2 ____/____/____ Dose#3 ____/____/____ Dose#4 ____/____/____
M D Y M D Y M D Y M D Y

TETANUS-DIPHThERIA-PERTUSSIS
Required
Primary series with booster with Tdap in the last ten years.
Tdap is recommended to protect against pertussis..... ____/____/____
M D Y

HEPATITIS B

Required

Three doses of vaccine or two doses of adult vaccine in adolescents 11-15 years of age or positive hepatitis B surface antibody meets the requirement.

1. Immunization (hepatitis B) Dose #1 ___/___/___ Dose #2 ___/___/___ Dose #3 ___/___/___
M D Y M D Y M D Y

OR

2. Immunization (Combined hepatitis A and B vaccine)

Dose #1 ___/___/___ Dose #2 ___/___/___ Dose #3 ___/___/___
M D Y M D Y M D Y

OR

3. Hepatitis B surface antibody Date ___/___/___ Result: Reactive ___ Non-reactive ___

Page 2/3

VARICELLA (Chicken Pox)

Required

(Birth in the U.S. before 1980, a history of chicken pox, a positive varicella antibody, or TWO doses of vaccine meets the requirement.)

1. History of Disease Yes ___ No ___ or Birth in the U.S. before 1980 Yes ___ No ___

OR

2. Varicella antibody ___/___/___ Result: Reactive ___ Non-reactive ___

OR

3. Immunization

a. Dose #1 M / D / Y

b. Dose #2 given at least 12 weeks after first dose ages 1-12 years..... M / D / Y
and at least 4 weeks after first dose if age 13 years or older.

OTHER IMMUNIZATIONS:

HUMAN PAPILLOMAVIRUS 9-Valent VACCINE (Gardasil-9)

(Three doses of vaccine for college students 11-26 years of age at 0, 2, and 6 month intervals.)

Dose #1 ___/___/___ Dose #2 ___/___/___ Dose #3 ___/___/___

HEPATITIS A

Dose #1 ___/___/___ Dose #2 ___/___/___

Typhoid ___/___/___

Yellow Fever ___/___/___

HEALTH CARE PROVIDER (must be signed by health care provider)

Name _____ **Address:** _____

I have discussed the risks/benefits of receiving the required immunizations with my provider. I will meet with the Director of Health Services and will sign a waiver for these immunizations before receiving a room key.

Student Signature: _____

