YORK COLLEGE OF PENNSYLVANIA | HEALTH SERVICES

IMMUNIZATION RECORD

If the immunization requirements are not met, the student will NOT be permitted to obtain their residence hall room key.
This form must be completed by a Healthcare Provider
ALL DATES FOR REQUIRED IMMUNIZATIONS MUST BE WRITTEN ON THIS FORM- no attachments will be accepted

NAME ____
Last First Middle

D.O.B. _______/________/________
Month Day Year

IF student does not have documentation of all required doses of vaccines:
BLOOD TEST REPORT SHOWING IMMUNITY MUST BE ATTACHED

REQUIRED IMMUNIZATIONS

THIS SECTION MUST BE COMPLETED AND FILLED OUT IN FULL BY MEDICAL PROVIDER
NO ATTACHMENTS WILL BE ACCEPTED

R E Q U I R E D I M M U N I Z A T I O N S

	1st Dose Date	2nd Dose Date	3rd Dose Date
1. **Hepatitis B** A 3-shot series is required. A blood test report indicating immunity is acceptable.			
2. **MMR** (Measles/Mumps/Rubella) Two (2) doses **after age 12 months**. A blood test report indicating immunity is acceptable.			
3. **Tdap** (Tetanus/Diphtheria/Pertussis) Vaccine **within 10 years.**			
4. **Varicella** (Chicken Pox) Two (2) doses **after age 12 months**. A blood test report indicating immunity is acceptable.			
Please note: Meningitis is a required immunization to live on campus and will require a waiver if you do not obtain			
5. **Meningitis** (Serogroup A,C,Y, W135) at least one dose **after age 16.** *Menactra, Menveo or Menomune*			
Meningitis B is "highly recommended" to live on campus .			
6. Meningitis B (Serogroup B) Minimum of two doses are required. Please indicate which brand received: ☐ *Bexsero - 2 dose series* OR ☐ *Trumenba - 2 or 3 dose series*			

R E Q U I R E D I M M U N I Z A T I O N S

OTHER IMMUNIZATIONS RECEIVED (highly recommended but not required)

COVID-19 Primary series and booster required. Please indicate which brand received. ☐ *Moderna* ☐ *Pfizer* ☐ *Johnson & Johnson* ☐ _______________				
Hepatitis A				
HPV (Human Papillomavirus Vaccine)				
Influenza				
Pneumococcal				
Polio				

I certify that to the best of my knowledge the information provided on this form is true and complete.

Date ______________________________ Healthcare Provider's Signature ____

Telephone: (____)____ Fax: (____)____

ONCE COMPLETED BY PROVIDER-STUDENT UPLOADS TO PYRAMED in Immunization History form