YORK COLLEGE OF PENNSYLVANIA | **IMMUNIZATION RECORD** | 2023/2024

If the immunization requirements are not met, the student will NOT be permitted to obtain their residence hall room key.
Please record dates (month/day/year) below AND include a copy of vaccine records from your medical provider.

NAME _____
Last First Middle

D.O.B. _____/_____/_____
Month Day Year

Student ID# _____/_____/_____

REQUIRED IMMUNIZATIONS

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THIS SECTION MUST BE COMPLETED AND FILLED OUT.
ANY BLOOD TEST REPORT SHOWING IMMUNITY MUST BE ATTACHED.

	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.	M/D/Y	M/D/Y	M/D/Y	
2. **MMR** (Measles/Mumps/Rubella) Two (2) doses **after age 12 months**. A blood test report indicating immunity is acceptable.	M/D/Y	M/D/Y		
3. **Tdap** (Tetanus/Diphtheria/Pertussis) Vaccine **within 10 years.**	M/D/Y			
4. **Varicella** (Chicken Pox) Two (2) doses **after age 12 months**. A blood test report indicating immunity is acceptable.	M/D/Y	M/D/Y		
IMMUNIZATONS AFTER AGE 16				
5. **Meningitis** (Serogroup A,C,Y, W135) at least one dose **after age 16.** *Menactra, Menveo or Menomune*	M/D/Y	M/D/Y		
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*	M/D/Y	M/D/Y	M/D/Y	

REQUIRED IMMUNIZATIONS

OTHER IMMUNIZATIONS RECEIVED (highly recommended but not required)

COVID-19 Primary series and booster required. Please indicate which brand received. ☐ *Moderna* ☐ *Pfizer* ☐ *Johnson & Johnson* ☐ _____	M/D/Y	M/D/Y	M/D/Y	M/D/Y
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: (____)_____