COMPLETE IMMUNIZATION HISTORY FORM 2023-2024

Healthcare Provider to Complete

STUDENT NAME_____**DATE OF BIRTH** _____

ALL STUDENTS – See Pennsylvania state immunization requirements listed below and have your healthcare provider complete the grid below. The provider's office form is also acceptable. RETURNING students only need to provide any immunizations received since last year's health forms were submitted.

The following vaccines are REQUIRED for school attendance by the State of Pennsylvania:

- 4 doses: Tetanus, diphtheria & acellular pertussis (1 dose on/after the 4th birthday): usually given as DTaP or DTP or DT or Td
- 1 dose: Tdap at or after age 11
- 4 doses: Polio (4th dose on/after the 4th birthday): a fourth dose of polio is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose
- 2 doses: MMR (two doses on/after age 1)
- 3 doses: Hepatitis B
- 2 doses: Varicella (chicken pox) or evidence of immunity with laboratory testing or a history of chickenpox disease
- 2 doses: Meningococcal conjugate vaccine
  - ➢ first dose given 11-15 years old, a second dose required PRIOR TO ENTRY into 12th grade (6th form)
  - ➢ If the first dose is given at 16 years or older, only one dose is required for 12th graders

Record dates with **EXACT** Month/Day/Year (MM/DD/YYYY)

REQUIRED BY PENNSYLVANIA	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
DTaP, DTP, DT, Td					
Tdap (1 dose)					
Polio IPV (OPV accepted) (1 dose after age 4)					
Hepatitis B (3 doses)					
MMR (2 doses on/after age 1)					
Varicella Vaccine (2 doses on/after age 1)					
History of Chicken Pox Disease or titer result	**Date:**	**Result:**			
Meningococcal Conjugate Vaccine: (circle) **Menactra, Menveo, or MenQuadfi**					
SARS-CoV-2 (COVID-19) ***(Indicate type and date for each dose)***					
RECOMMENDED: (student to discuss with healthcare provider if vaccine is recommended)					
Meningococcal B vaccine **Bexsero or Trumenba** (circle)					
Gardasil					

Healthcare provider signature:_____**Printed name:**_____

Healthcare provider address:_____

Phone:_____**Fax:**_____