

COMPLETE IMMUNIZATION HISTORY FORM 2025-2026

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, MenQuadfi, or Penbraya					
EXPECTED					
SARS-CoV-2 (COVID-19) (Indicate type and date for each dose; waiver required if not vaccinated with at least 1 dose)					
RECOMMENDED: (student to discuss with healthcare provider if vaccine is recommended)					
Meningococcal B vaccine Bexsero, Trumenba, or Penbraya (circle)					
Gardasil					

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

Healthcare provider address: _____

Phone: _____ **Fax:** _____