Gettysburg College Health Service **300 N. Washington Street, Gettysburg, PA 17325**
Phone: (717)337-6970 Fax: (717-337-6978)

Immunization Record – To Be Completed By Physician/HCP Office

Name_____ **DOB**_____/_____/_____
Last First Middle

Required Immunizations	**1st Dose**	**2nd Dose**	**3rd Dose**
1. Hepatitis B A 3-shot series is required. Blood test showing immunity is acceptable. Attach/upload copy of testing.	M /D/ Y	M /D/ Y	M /D /Y
2. MMR (Measles/Mumps/Rubella) Two (2) doses after age 12 months given at least 28 days apart. Blood test indicating immunity is acceptable. Attach/upload copy of testing.	M/ D/ Y	M/ D/ Y	
3. Meningitis - Serogroup A,C,Y, W135 Menactra, Menveo, Menomune	M/ D/ Y	M/ D /Y	
4. Meningitis Serogroup B Bexsero or Trumenba			
Bexsero	M/ D/ Y	M/ D/ Y	
Trumenba	M/ D/ Y	M/ D/ Y	M/ D/ Y
5. Polio (OPV or IPV) Provide completed series date	M/ D/ Y		
6. Tdap (Tetanus/Diphtheria/Pertussis) Vaccine **(within 10 years)**			
7. Varicella (Chicken Pox) ***Two doses Required** Blood test indicating immunity is acceptable. Attach/upload copy of testing.	M/ D/ Y	M/ D/ Y	
OR History of Varicella Disease	M/ D/ Y		

Highly Recommended Vaccines **(NOT REQUIRED)**

	1st Dose Date	2nd Dose Date	3rd Dose Date
Hepatitis A			
HPV (Human Papillomavirus Vaccine)			

Physician/HCP Name_____

Signature_____ Date_____

Address or stamp_____

Telephone _____Fax_____

NOTE TO STUDENT: Please go to your "**To Do List"** Uploads Feature on your Medicat Student Patient Portal and after you have entered your immunization record, please **upload this copy.**