Gettysburg College Health Center by Wellspan Health
Phone: 717-337-4105|Fax: 717-798-3407|Health_Services@cnav.gettysburg.edu
300 N Washington St, Gettysburg, PA 17325

Immunization Record – To Be Completed By Physician/HCP Office

Name_____ DOB_____
Last First Middle

ALL REQUIRED IMMUNIZATIONS AND THEIR SPECIFIC NUMBER OF DOSES ARE REQUIRED TO BE CONSIDERED IN COMPLIANCE BY THE COLLEGE

REQUIRED IMMUNIZATIONS	1ST DOSE	2ND DOSE	3RD DOSE
Hepatitis B A 3-shot series is required. Blood test showing immunity is acceptable. Attach/upload copy of testing.	M/D/Y Click or tap here to enter text.	M/D/Y Click or tap here to enter text.	M/D/Y Click or tap here to enter text.
MMR (Measles/Mumps/Rubella) Two (2) doses after age 12 months given at least 28 days apart. Blood test showing immunity is acceptable. Attach/upload copy of testing.	M/D/Y Click or tap here to enter text.	M/D/Y Click or tap here to enter text.	**(NOT APPLICABLE)**
Meningitis – Serogroup A, C, Y, W Menactra, Menveo, Menomune First dose preferably between ages 11-12. Second dose after age 16.	M/D/Y Click or tap here to enter text.	M/D/Y Click or tap here to enter text.	**(NOT APPLICABLE)**
Polio (OPV or IPV) Provide completed series date.	M/D/Y Click or tap here to enter text.	**(NOT APPLICABLE)**	**(NOT APPLICABLE)**
TDAP (Tetanus/Diphtheria/Pertussis) Vaccine (Within 10 years)	M/D/Y Click or tap here to enter text.	**(NOT APPLICABLE)**	**(NOT APPLICABLE)**
Varicella (Chicken Pox) ***Two (2) doses required.** Blood test showing immunity is acceptable. Attach/upload copy of testing.	M/D/Y Click or tap here to enter text.	M/D/Y Click or tap here to enter text.	**(NOT APPLICABLE)**
OR HISTORY OF VARICELLA DISEASE	M/D/Y Click or tap here to enter text.	**(NOT APPLICABLE)**	**(NOT APPLICABLE)**

HIGHLY RECOMMENDED IMMUNIZATIONS (NOT REQUIRED)	1ST DOSE	2ND DOSE	3RD DOSE	4TH DOSE
COVID-19 Vaccine Please list the name of the COVID-19 Vaccine (Pfizer, Moderna, Johnson & Johnson, etc.) received below:	M/D/Y Click or tap here to enter text.	M/D/Y Click or tap here to enter text.	M/D/Y Click or tap here to enter text.	M/D/Y Click or tap here to enter text.
Meningitis Serogroup B Preferred Age: 16 through 18 Bexsero (2 Doses) OR Trumenba (3 Doses)	M/D/Y Click or tap here to enter text.	M/D/Y Click or tap here to enter text.	M/D/Y Click or tap here to enter text.	**(NOT APPLICABLE)**
Hepatitis A	M/D/Y Click or tap here to enter text.	M/D/Y Click or tap here to enter text.	**(NOT APPLICABLE)**	**(NOT APPLICABLE)**
HPV (Human Papillomavirus Vaccine)	M/D/Y Click or tap here to enter text.	M/D/Y Click or tap here to enter text.	M/D/Y Click or tap here to enter text.	**(NOT APPLICABLE)**

STUDENTS NOT BORN IN THE UNITED STATES:

Have you received the BCG Vaccine? NO__☐___ YES__☐___ IF YES, DATE_____

Physician/HCP Name_____

Signature_____

Address or Stamp_____

Telephone_____ Fax_____

NOTE TO STUDENT: Please go to your **Medicat Student Patient Portal – Immunizations –** and enter all the dates of your immunizations as shown on your immunization record. Upon completion of entering your immunizations, please **upload a copy of your immunization record via the Patient Portal Upload feature.**

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