Pennsylvania College of Technology
A Penn State Affiliate

All Incoming Students
Medical Provider Immunization Form

College Health Services • 570.320.5234 • 570.329.4947 (fax)

PART I: Completed by student. Please print.

Student _____
Last name *First name* *Date of birth*

_____
ID number *Cell/home phone*

I hereby authorize, and give my consent to, the medical provider completing this form to release the information herein to Penn College College Health Services.

Student signature _____ Date_____/_____/_____
MM *DD* *YYYY*

Upload completed form and supporting documentation to the College Health Portal at pct.studenthealthportal.com (use Penn College network username and password).

You will receive Secure Messages through the College Health Portal. Look for the following:

Secure Message From Penn College Health Services
Penn College Health Portal <*noreply@studenthealthportal.com*>
To: Hello student,
You have received a new Secure Message via the Penn College Health Portal. Please click here to retrieve your message.
Thank you,
Penn College Health Services
570-320-5234

PART II: To be completed and signed by your healthcare provider. *All information must be in English.*
Required for all students.

1. Hepatitis B Dose #1 _____/_____/_____ Dose #2 _____/_____/_____ Dose #3 _____/_____/_____
MM DD YYYY

2. Varicella 1. History of disease ☐ Yes ☐ No

2. Immunization Dose #1 _____/_____/_____ Dose #2 _____/_____/_____
MM DD YYYY

3. MMR (Measles, Mumps, Rubella) Dose #1 _____/_____/_____ Dose #2 _____/_____/_____
MM DD YYYY

4. Meningococcal Conjugate (MCV4) *Dose#2 : Required documentation before moving on campus. Age 23 or older exempt.*

Dose #1 _____/_____/_____ Dose #2 *(on or after 16th birthday)* _____/_____/_____
MM DD YYYY

Specify type (e.g., Menactra / Menveo / Menquadfi) _____

5. Tetanus *Must be within the last 10 years.*

Tdap (Adacel/Boostrix) _____/_____/_____ **or** Td _____/_____/_____
MM DD YYYY

Recommended for students under the age of 23.

6. Meningococcal Serougroup B *Age 23 or older exempt. Not required, but strongly recommended.*

Dose #1 _____/_____/_____ Dose #2 _____/_____/_____
MM DD YYYY

Specify type (e.g., Bexsero/Trumenba) _____

HEALTHCARE PROVIDER: Return this completed form and/or provide a copy of any immunization records to the student.

* Students may have additional or different clinical requirements upon acceptance into Nursing & Health Science (NHS) programs.

Office stamp or address

_____
Name (print)

_____
Medical provider signature

_____
Office phone number

PC 1952 11/23