



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 MyHealth Online at pct.medicatconnect.com (use Penn College network username and password).

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

1. Meningococcal Conjugate (MCV4) Age 23 or older exempt.

One dose (on or after 16th birthday) MM / DD / YYYY

Specify type (e.g., Menactra) _____

2. MMR (Measles, Mumps, Rubella)

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

3. Tetanus Must be within the last 10 years.

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

4. Hepatitis B

Dose #1 MM / DD / YYYY Dose #2 MM / DD / YYYY Dose #3 MM / DD / YYYY

5. Varicella

1. History of disease Yes No

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

6. Meningococcal Serogroup B Age 23 or older exempt.

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

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

HEALTHCARE PROVIDER: Provide this completed form and 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.

Name (print)

Medical provider signature

Office phone number

Office stamp or address
