



# Department of Health

# IMMUNIZATION RECORD

## SECTION TWO

**PERSONAL HEALTH INFORMATION** Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_

**IMMUNIZATION RECORD** (Asterisks denote minimum mandatory vaccine to comply with PA regulations)

Vaccine	Date each dose was given				
	1st Month/Day/Year	2nd Month/Day/Year	3rd Month/Day/Year	4th Month/Day/Year	5th Month/Day/Year
<b>DTP</b> (Diphtheria, Tetanus, Pertussis) 3 Doses Required	*	*	*		
<b>Tdap Booster</b> (Tetanus, Diphtheria, Acellular Pertussis) Must be within 5 years					
<b>POLIO Vaccine</b> IPV – 4 Doses Required OR OPV – 3 Doses Required	IPV 1*	IPV 2*	IPV 3*	IPV 4*	IPV 5
	OPV 1*	OPV 2*	OPV 3*		
<b>MMR</b> (Measles, Mumps, Rubella, Combined) 2 Doses Required	*	*			
<b>O R</b>	<b>**Measles</b> (Rubeola: 10 Day Red Measles) 2 Doses of Individual Vaccine Required	*	*	If no immunization, give date student had measles:	
	<b>**Rubella</b> (German Measles-3 Days) 1 Dose of Individual Vaccine Required	*		If no immunization, give date student had Rubella:	
	<b>**Mumps</b> 2 Doses of Individual Vaccine Required	*	*	If no immunization, give date student had Mumps:	
<b>Hepatitis B</b> 3 Doses Required	*	*	*		
<b>Varicella</b> 2 Doses Required	*	*		If no immunization, give <b>date</b> student had Chickenpox: Vaccine, positive titer or physician's documentation of disease for student entering grade 7 - 12	
<b>Meningococcal Conjugate Vaccine (MCV)</b> 1 Dose Required Must be within the last 5 years	*	MCV may be administered as a single antigen vaccine or in a combination form			
<b>Other Vaccines Received</b> (Please list vaccine(s) with dates)					

\*\*If the student has had measles, mumps or rubella and has not received a vaccine for it, a positive titer (blood test) to document immunity must be submitted. A paper from the doctor must be included.

### Tuberculosis Clearance (International Students Only)

Skin Test: Date: \_\_\_\_\_ Positive or Negative \_\_\_\_\_ If skin test is POSITIVE, an X-Ray is required:

Chest X-Ray: Date: \_\_\_\_\_ Positive or Negative \_\_\_\_\_

If chest x-ray is positive, what treatment was given? \_\_\_\_\_

### Physician Information

Physician's Signature or Stamp Required \_\_\_\_\_ Date \_\_\_\_\_ Physician's Name (Please Print) \_\_\_\_\_

Physician's Address \_\_\_\_\_ City \_\_\_\_\_ State/Province \_\_\_\_\_ Country \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_

Physician's Phone (Include ALL Country, City, and Area Codes) \_\_\_\_\_ Physician's Fax (Include ALL Country, City, and Area Codes) \_\_\_\_\_

**ATTENTION BOARDING STUDENTS: Pennsylvania International Academy complies with State regulations governing immunization requirements. Any required immunizations not obtained prior to your arrival will be administered after you arrive, and any fees for obtaining them will be billed to the student's account.**

Parents/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_