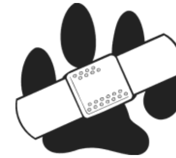
BARTON COMMUNITY COLLEGE
STUDENT HEALTH SERVICES
IMMUNIZATION RECORD



To be completed and signed by a healthcare provider, health department or attach copy of official records.

NAME____
DATE OF BIRTH____

REQUIRED FOR CAMPUS HOUSING;

MENINGOCOCCAL MENINGITIS Circle type administered	**MENACTRA** MCV4	**MENOMUNE** MPSV4	#1 MM/DD/YYYY	

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MMR MMR: _____________ Or Measles:____________ Mumps:____________ Rubella:____________	#1 MM/DD/YYYY ____________________ ____________________ ____________________ ____________________	#2 MM/DD/YYYY ____________________ ____________________ ____________________ ____________________ Must be **AFTER 1980**	Titer Results MM/DD/YYYY ____________________ ____________________ Use ONLY if vaccination requirement not met	

DPT Primary series with Dtap,DPT or Td and booster with Td or Adacel in last ten years meets the recommendations.	#1 MM/DD/YYYY	#2 MM/DD/YYYY	#3 MM/DD/YYYY	#4 MM/DD/YYYY	**Last booster must be within ten years** MM/DD/YYYY Circle one-Td or Adacel
POLIO Primary series in child-hood meets the requirement.	#1 MM/DD/YYYY	#2 MM/DD/YYYY	#3 MM/DD/YYYY	#4 MM/DD/YYYY	
VARICELLA (Chicken Pox)	#1 MM/DD/YYYY	#2 MM/DD/YYYY	Titer Results MM/DD/YYYY	History of Disease MM/DD/YYYY	
TWINRIX (Combined Hepatitis A and Hepatitis B)	#1 MM/DD/YYYY	#2 MM/DD/YYYY	#3 MM/DD/YYYY		
HEPATTIS A Immunization Series	#1 MM/DD/YYYY	#2 MM/DD/YYYY			
HEPATITIS B Immunization Series	#1 MM/DD/YYYY	#2 MM/DD/YYYY	#3 MM/DD/YYYY	Titer Results MM/DD/YYYY	
TB SKIN TEST	Date Given— Location— Per--		**READ**	Date read— ___________mm Per—	

To the best of my knowledge the above information is accurate:

Provider Signature:____/____________________
Physician/Nurse Date