

BARTON COUNTY 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 _____ _____	Titer Results MM/DD/YYYY _____ _____	
		Must be AFTER 1980	Use ONLY if vaccination requirement not met	

DPT Primary series with Dtap, DPT or Td and booster with Td or Tdap 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 Tdap
POLIO Primary series in childhood 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		
HEPATITIS 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	

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

Provider Signature: _____ / _____
Physician/Nurse Date