BARTON
STUDENT HEALTH

IMMUNIZATION RECORD

To be completed, signed <u>and</u> stamped by a healthcare provider/health department <u>AND attach copy of official records</u>.

FIRST NAME_____ LAST NAME_____MI __
DATE OF BIRTH_____
STUDENT ID# _____

*** <u>REQUIRED FOR CAMPUS HOUSING</u>** or complete waiver

*** MENINGOCOCCAL ACWY (MENINGITIS)** (*administered at 16 years of age or after*)	MM/DD/YYYY Type			

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MMR Or Measles Mumps Rubella	#1 MM/DD/YYYY _____ _____ _____ _____ Administered after 12mo of age	#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 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	**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	
Meningitis B (administered at 16 years of age or after)	#1 MM/DD/YYYY	#2 (Booster) (Administered 6 months after initial dose) MM/DD/YYYY			
TB SKIN TEST – Must be completed in the United States	Date Given _____ Location _____ Signature _____		**READ**	Date read _____ _____mm Signature _____	

To the best of my knowledge, the above information is accurate:
Healthcare Provider Address: _____ State ____ Zip Code _____ Phone _____
Provider Signature: _____/_____
Physician/Nurse Date

08/25