

**BARTON COUNTY COMMUNITY COLLEGE  
ALLIED HEALTH PROGRAMS**

**Immunization Record**  
(To be completed by the student)

Student Name \_\_\_\_\_  
Last First Middle

1. Tuberculin (TB) Yearly Skin Test: one within past six months

Date \_\_\_\_\_ Result \_\_\_\_\_

Note: If student has a positive reaction, results of current chest x-ray must be submitted. **Student must provide documentation** of yearly TB test.

2. Tetanus/Diphtheria or Tdap (if your Tetanus is older than two years old we require that you to get a Tdap)

Type \_\_\_\_\_ Date \_\_\_\_\_

3. MMR (measles, mumps, rubella)

Born prior to 1957 give year of birth \_\_\_\_\_

Born after 1957, you must have two MMRs or documented positive titer.

#1 Date \_\_\_\_\_ #2 Date \_\_\_\_\_

Have had measles \_\_\_\_\_, mumps \_\_\_\_\_, rubella \_\_\_\_\_  
Year Year Year

4. Chicken Pox

Have had \_\_\_\_\_, or titer \_\_\_\_\_, or vaccination \_\_\_\_\_  
Year Year Year

5. Hepatitis B Vaccine

\_\_\_\_\_ I refuse to receive HBV at this time.

Initial Here

\_\_\_\_\_ I have received the HBV series.

Initial Here

#1 Date \_\_\_\_\_ #2 Date \_\_\_\_\_ #3 Date \_\_\_\_\_

\_\_\_\_\_

Date

\_\_\_\_\_

Student Signature

**Submit documentation** with either the date of disease, immunization record, and/or titers of all of the above diseases to be kept with your file.