BARTON
STUDENT HEALTH

IMMUNIZATION RECORD

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

FIRST NAME_____ LAST NAME_____MI __
DATE OF BIRTH_____

REQUIRED FOR CAMPUS HOUSING or complete waiver

MENINGOCOCCAL (MENINGITIS)	#1 MM/DD/YYYY Type	Booster 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 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 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:
Healthcare Provider Address: _____ State ____ Zip Code _____ Phone _____
Provider Signature:_____/_____
Physician/Nurse Date