

VACCINE		RECORD THE DATE EACH DOSE OF VACCINE WAS RECEIVED (to be completed by the Health Department or Physician, not the student)									
		1 st	2 nd	3 rd	4 th	5 th	6 th	7 th			
Tdap, DTP, DTaP and dT/Td Must show booster within last ten (10) years. Tdap must be given if 2 or more years since last booster. <u>CIRCLE TYPE</u>		Tdap, DTP, DTap, dT/Td Mo. Day. Yr. - -	Tdap, DTP, DTap, dT/Td Mo. Day. Yr. - -	Tdap, DTP, DTap, dT/Td Mo. Day. Yr. - -	Tdap, DTP, DTap, dT/Td Mo. Day. Yr. - -	Tdap, DTP, DTap, dT/Td Mo. Day. Yr. - -	Tdap, DTP, DTap, dT/Td Mo. Day. Yr. - -	Tdap, DTP, DTap, dT/Td Mo. Day. Yr. - -			
MMR (<i>Measles, Mumps, and Rubella combined</i>) Proof of two (2) required. (If born before 1957 only 1 required)		- -	- -	Give TB skin test first ; then MMR and/or Varicella. MMR & Varicella MUST be given after the 2-step skin test. Otherwise the skin test results may be invalid and will need to be repeated. There is a 30-day waiting period if MMR or Varicella is given prior to the TB skin test. If MMR and Varicella are both needed, give on the same day or there is a 30-day waiting period between each injection.							
Single Antigen Dose Only	MEASLES (Rubella/red measles/ 10-day measles)	- -	- -								
	RUBELLA (German Measles/3-day measles)	- -	- -								
	MUMPS										
Varicella (<i>Chickenpox</i>) (If no vaccination, give date of disease _____ or submit titer).		- -	- -								
HBV (Hepatitis B Vaccine) Recommended for health care workers. <u>CIRCLE TYPE (HepA/B or Hep B)</u>		Hep A/B, Hep B - -	Hep A/B, Hep B - -	Hep A/B, Hep B - -							
Pneumonia Immunization (Encouraged if history of pneumonia, asthma, or lung disease).		- -									
Flu Vaccine (consider during flu season).		- -	- -	- -	- -	- -	- -	- -			
HAV (Hepatitis A Vaccine) <i>Optional</i>		- -	- -	- -							
Meningococcal Vaccine <i>Recommended but Optional</i>		- -									
DOCUMENTATION I certify I reviewed this student's vaccination record and transcribed it accurately. Signature _____ Date ____ - ____ - ____ Name of Agency _____ The record presented was: <input type="checkbox"/> Kansas Immunization Record (pink card). <input type="checkbox"/> Other Immunization record (Specify _____). <input type="checkbox"/> School Record.		A 2-step (1-3 weeks apart) PPD Tuberculin Test must be completed within the last three months. (One-step is accepted only if initial 2-step & annual one-stet can be evidenced) Only intradermal skin tests are accepted. A chest x-ray (14"x17") is required for positive reactors to the tuberculin test. Report _____ Date _____. If positive reactor with chest x-ray on file, student must document absence of symptoms and awareness of need to report occurrence of TB symptoms to Butler College Health Service (322-3371) should they develop*. A negative Quantiferon (QFT) annually is also accepted as proof of negative TB.			Two Step Tuberculin Skin Test	Date Given	Given By	Date Read	Read By	mm indur Requid red	
					Intradermal PPD ONLY ←					mm	<input type="checkbox"/> Significant <input type="checkbox"/> Non-Significant
					Intradermal PPD ONLY (1-3 weeks after above date) ↑					mm	<input type="checkbox"/> Significant <input type="checkbox"/> Non-Significant

*If the student has a positive PPD or QFT and an abnormal Chest X-ray and/or symptoms of active TB (cough lasting > 3 weeks, fatigue, night sweats, weight loss, anorexia, ect.) three sputum **MUST** be negative before the student will be allowed to attend class and treatment will be mandatory.

Fax, mail, or bring this completed form to the Allied Health Office in the 9100 building or bring it with you the first day of class.