

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 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)	- - -	- - -	- - -	- - -	- - -	- - -	- - -
Single Antigen Dose Only MEASLES (Rubella/red measles/10-day measles) RUBELLA (German Measles/3-day measles) MUMPS	- - -	- - -	- - -	- - -	- - -	- - -	- - -

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.

Varicella (<i>Chickenpox</i>) (If no vaccination, give date of disease <u> </u> or submit titer).	- - -	- - -	- - -	- - -	- - -	- - -	- - -
HBV (Hepatitis B Vaccine) Recommended for health care workers. <u>CIRCLE TYPE</u> (<i>HepA/B or HepB</i>)	Hep A/B, HepB - - -	Hep A/B, HepB - - -	Hep A/B, HepB - - -	Hep A/B, HepB - - -	Hep A/B, HepB - - -	Hep A/B, HepB - - -	Hep A/B, HepB - - -
Pneumonia Immunization (Encouraged if history of pneumonia, asthma, or lung disease)	- - -	- - -	- - -	- - -	- - -	- - -	- - -
Flu Vaccine (Consider during flu season).	- - -	- - -	- - -	- - -	- - -	- - -	- - -
HA V(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:

Kansas Immunization Record (pink card)

Other Immunization record (Specify _____)

School record

<u>Two Step Tuberculin Skin Test</u>	Date Given	Given By	Date Read	Read By	mm indur Requi red	Signifi cant Non- Signifi cant
① Intra Dermal PPD ONLY					_____ mm	<input type="checkbox"/> Signifi cant <input type="checkbox"/> Non- Signifi cant
② Intra Dermal PPD ONLY (1-3 weeks after above date)					_____ mm	<input type="checkbox"/> Signifi cant <input type="checkbox"/> Non- Signifi cant

A two-step(1-3 weeks apart) PPD Tuberculin Test must be completed within the last three months. (One-step is accepted only if initial two-step & annual one-step 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.

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

Office Use Only: CPR Renewal Date: _____