

### Butler Community College Immunization Requirements

Student Name \_\_\_\_\_ Sex: M  F  Birthdate: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Telephone Number (\_\_\_\_) \_\_\_\_\_

**Required Immunizations for Residents:** Tetanus within last 10 years, 2- MMR's, Meningitis (signed waiver refusing).

**Immunizations that are recommended but NOT required:** Varicella, Hep B, Hep A, Pneumonia, and Influenza.

VACCINE <i>All information MUST be in English</i>		RECORD THE DATE EACH DOSE OF VACCINE WAS RECEIVED (To be completed or signed by the Health Department or Physician, NOT the student)									
<b>DTP, DTaP, and dT/Td, or Tdap* Must show booster within last ten (10) years. International sts need total of 3 Circle type</b>		DT DtaP Td Tdap - -	DT DtaP Td Tdap - -	DT DtaP Td Tdap - -	DT DtaP Td Tdap - -	DT DtaP Td Tdap - -	DT DtaP Td Tdap - -	DT DtaP Td Tdap - -	DT DtaP Td Tdap - -		
MMR (Measles, Mumps, & Rubella combined) <b>Proof of two (2) required.</b> (If born before 1957 only 1 required.)		- -	- -								
Single Antigen Dose Only	<b>MEASLES</b> <i>(Rubeola/red/measles/10-day measles)</i> <b>RUBELLA</b> <i>(German Measles/3-day measles)</i> <b>MUMPS</b>										
Meningococcal Menactra* only 1 required. Menimmune lasts 3-5 years		- -	- -								
Varicella (Chickenpox) Antibody Titer or <b>Disease.</b> Recommendation: <b>1 dose if given before age 13. Two doses if given at age 13. (optional).</b> Required for Kindergarten and First Grade entry for 2005-06 school year in Kansas.		- -	- -	Date of disease _____ Parent/Physician Signature _____							
Hep B HBV (Hepatitis B Vaccine) <b>(optional)</b> Recommended for health care workers and ALL children Required for Kindergarten and First Grade entry for 2005-06 school year in Kansas.		- -	- -	- -	Additional Doses: _____ _____ _____						
Hep A HAV (Hepatitis A Vaccine) Recommended for selected populations <b>(optional)</b>		- -	- -	- -							
Pneumonia Immunization (Encouraged if high risk for pneumonia or chronic illness). <b>(Optional)</b>		- -	- -	- -							
Influenza Vaccine (flu) (Consider during flu season) <b>(Optional)</b>		- -	- -	- -							
<b>DOCUMENTATION</b>		<b>International Students:</b> A PPD Tuberculin Test must be completed within the <b>last three months.</b> Only intradermal skin tests are accepted. A chest X-ray (14"X17") is required for positive reactions to the tuberculin test. Report _____ Date _____ If the student is a positive reactor with a negative chest x-ray on file, the student must document absence of symptoms and an awareness of the need to report occurrence of TB symptoms to Butler College Health Service (322-3371) should they develop. ***			<b>Tuberculin Test</b>	Date Given	Given By	Date Read	Read By	<b>mm induration required</b>	
<b>PARENTS, STUDENTS, AND/OR GUARDIANS ARE NOT AUTHORIZED TO COMPLETE FORM.</b> I certify I reviewed this student's vaccination record and transcribed it accurately. Signature _____ Date ____ - ____ - ____  Name & Title (Printed) _____  Name of Agency _____ The record presented was: _____ Date ____ - ____ - ____ <input type="checkbox"/> Kansas Immunization Record (pink card) <input type="checkbox"/> Other immunization record (Specify _____) <input type="checkbox"/> School record					<b>Intra Dermal PPD ONLY</b>					____ mm **	<input type="checkbox"/> Non-Significant <input type="checkbox"/> Significant
		<b>Intra Dermal PPD ONLY</b>					____ mm **	<input type="checkbox"/> Non-Significant <input type="checkbox"/> Significant			
		If Positive PPD and negative Chest does the student show Signs or symptoms of active Tuberculosis disease? Yes____ No____				Has INH Prophylaxis been offered? Yes ____ No ____ If yes, Completion date? _____					

\*If possible give Tdap and Menactra at the same time. \*\*If TB skin test results are between 5mm-9mm a 2-step TB skin test will be required.

\*\*\*If the student has a positive PPD and an abnormal chest X-ray and/or signs and symptoms of TB (cough lasting > 3 wks, fatigue, night sweats, weight loss, anorexia, etc.), three sputums MUST be negative before student will be allowed to attend class and Treatment will be mandatory.

**Give TB skin test First, then MMR and/or Varicella. MMR and Varicella MUST be given after the TB skin test or, the skin test results will 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.**

**BUTLER COMMUNITY COLLEGE  
MEDICAL & EMERGENCY INFORMATION WAIVER**

*(Please Print Clearly)*

**Full Name:** \_\_\_\_\_

**Social Security #:** \_\_\_\_\_ **Birthdate:** \_\_\_\_\_

**Home Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip Code:** \_\_\_\_\_

**Parent(s) Name(s):** \_\_\_\_\_

**In Case of Emergency Contact:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Or Contact:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Family Doctor's Name:** \_\_\_\_\_

**Office Phone #:** \_\_\_\_\_ **Home Phone #:** \_\_\_\_\_

**Medical or Physical conditions that require special attention:**

\_\_\_\_\_

**Any Medications taken on a regular basis:**

\_\_\_\_\_

**Health Insurance Company:** \_\_\_\_\_

**Group # and Policy #:** \_\_\_\_\_

**Required Immunization Records Can Be Attached To This Wavier And Any Immunization Information Can Be Put On The Back Of This Wavier By An Appropriate Medical Official.**

*I, the under signed, understand that by signing this document I have given permission to Butler Community College and or its representative to admit this resident to emergency care such as Emergency Room or Ambulance when deemed necessary.*

\_\_\_\_\_  
**Residence Hall Resident**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent or Guardian**

\_\_\_\_\_  
**Date**

**Over**