Student Name _____
Please print: *Last* *First* *Middle*

Home Address _____
Street/PO Box *City* *State* *Zip*

Student ID# _____ Date of Birth ____/____/____
mm *dd* *yy*

Email Address _____

TO THE EXAMINING HEALTH CARE PROVIDER: Please review and complete this BCC Immunization Report.

2	Varicella: Proof of positive titer that demonstrates immunity. If immunity is		
			Plant date:
			Read date
5	T-dap vaccine: 1 dose; and history of a DTaP primary series or age appropriate catch-up vaccination. Within 10 years prior to clinical assignment/ observation.	Tdap date:	
6	Meningoccal: 1 dose MenACWY required for all full-time students 21 years of age or younger.	Date:	
7	Covid-19 vaccine: completed series. If booster received, please include.	Vaccine manufacturer:	1.
			2.
		Booster manufacturer:	1.
8	Flu vaccine: during fu season (October-March)	Date:	
9	Ishihara Test: Required for faculty and students who need to identify color for specifc tests, such as POC testing		