Kansas City Kansas Community College

Immunizations

Name (please print):_____ Student ID:_____

Date of Birth:_____ Phone:_____ Email:_____

1. MMR: Measles, Mumps, Rubella vaccination is required for all newly enrolled or reenrolled KCKCC students who were born after January 1957.

#1 Must be on or after 1st birthday MMR:_____ -or- Measles:_____ Mumps:_____ Rubella:_____	#2: Must be at least 28 days after 1st MMR vaccination MMR:_____ -or- Measles:_____ Mumps:_____ Rubella:_____	OR: Serology confirming immunity: Please attached lab results

2. Meningococcal meningitis vaccination (MCV4 or MPSV4) is required for all students in Student Housing at KCKCC. Other vaccinations are unacceptable. Vaccine must be given after the 16th birthday to be accepted.
   MCV4 – MENACTRA/MENVEO **OR:** MPSV4 – MENOMUNE

   MM/DD/YYYY:_____ MM/DD/YYYY:_____

3. Tuberculosis questionnaire must be completed within the Housing system. If you answered yes to any of the questions, you will be required to undergo Tuberculosis Testing. Either a PPD or Quantiferon testing is acceptable. This testing must be done in the United States.

   PPD Date:_____ **OR:** Quantiferon Date:_____

4. COVID-19 vaccination is required for all students in Student Housing at KCKCC. Students who do not show proof of vaccination (including recommended boosters) will be required to complete weekly testing.

   Vaccine #1_____ Vaccine #2_____ Booster_____

5. Recommended Immunizations

Hepatitis A series	#1 MM/DD/YYYY	#2 MM/DD/YYYY			
Hepatitis B series	#1 MM/DD/YYYY	#2 MM/DD/YYYY	#3 MM/DD/YYYY	Titer Results (Attach copy of results)	
Hepatitis A/B combined	#1 MM/DD/YYYY	#2 MM/DD/YYYY	#3 MM/DD/YYYY		
DPT/TDAP Primary series with dtap, dept or td and booster with td or tdap in last 10 years meets recommendation	#1 MM/DD/YYYY	#2 MM/DD/YYYY	#3 MM/DD/YYYY	#4 MM/DD/YYYY	Date of Last Booster Td:_____ OR Tdap:_____
Polio	#1 MM/DD/YYYY	#2 MM/DD/YYYY	#3 MM/DD/YYYY	#4 MM/DD/YYYY	
Human Papillomavirus	#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 (Attach copy of results)	History of Disease	

Your healthcare provide must complete this form.

Provider signature:_____ **Date**:_____