utmb Health
Student Health

UTMB STUDENT HEALTH IMMUNIZATION RECORD

Name:_____ **Date of Birth:** _____ **Student ID #:**_____

UTMB - For Currently Enrolled / Returning Students

Circle School: SOM SHP SON GSBS MD&PHD

Provide Program:

Provide Initial Entering Term & School Year:

Term: **Year:**

UTMB - For New Prospective/Incoming Students

Circle School: SOM SHP SON GSBS MD&PHD

Provide Program:

Circle Entering Term & School Year

Spring Summer Fall

Year: 2015 2016 2017 2018

Galveston College Students

Please Circle the Appropriate Program:

LVN LVN to RN A.D.N. Phlebotomy

CTMT RADR RADT MRIT NMTT EMS

Circle Entering Term & School Year

New or Returning / Spring Summer Fall

Year: 2015 2016 2017 2018

Please refer to the immunization Requirement Sheet to determine what is required.
(In order for your record to be processed, please complete all information above and below with supported printed or scanned documentation.)

Bacterial Meningitis Vaccine (See School Requirements)

Must be within 5 years and 10 days before the first class day.

Date:_____

Tetanus, Diphtheria, Pertussis (Tdap) (This is an adult immunization not the childhood series)

Date:_____

Tetanus, Diphtheria (Td) (10 years after adult Tdap)

Date:_____

MMR (Measles, Mumps & Rubella)

Born in or after 1957, two (2) doses are required.
Born before 1957, one (1) dose is required or proof of positive titer results.

#1 Date:_____ #2 Date:_____

OR

Please attach lab reports

Measles Titer: _____ Result :_____

Mumps Titer: _____ Result: _____

Rubella Titer: _____ Result: _____
(Titers may be required for some clinical rotations)

Varicella (Chicken pox)

Two doses of Varicella Vaccine

#1 Date: _____ #2 Date: _____

Date of illness: _____ (Must have positive titer to confirm)

OR

report of a positive titer is required for all students.

Please attach lab report

Titer Date: _____ **Result:** _____

Tuberculin Test (PPD) Screening

Must be within 12 months of the first day of class. Date:_____ Reading: _____mm Induration

(**Add'l readings to be complete by Office Staff only):** Date:_____ Reading: _____mm Induration Date:_____ Reading: _____mm Induration

Date:_____ Reading: _____mm Induration Date:_____ Reading: _____mm Induration

History of Positive PPD: Positive PPD Date: _____ INH Medication Taken: Yes No Chest X-Ray Date:_____ Report: _____

(Screenings to be documented by Office Staff only): TB evaluation Annual Screening Dates:_____, _____, _____, _____

QuantiFERON–TB Gold Test Date:_____ Result:_____ T-SPOT Date:_____ Result:_____

Hepatitis B

Completed series (3 doses) and positive titer (Hepatitis B surface antibody). (If titer antibody is negative, repeat series.)

1st Series

#1 Date: _____ #2 Date: _____

#3 Date: _____

Please attach lab report

Titer Date: Result:

2nd Series

#4 Date:_____ #5 Date: _____

#6 Date: _____

Titer Date: Result:

OR Hepatitis A&B Combination

#1 Date: _____ #2 Date:_____

#3 Date: _____

Titer Date: Result:

Influenza

School Year:_____
Date:_____

School Year:_____
Date:_____

School Year:_____
Date:_____

I verify that the above information is an accurate report. **(One of the below listed medical providers can list all immunizations and sign as official documentation. It does not have to be signed if turning in official paper documentation with this completed form.)**

MD, DO,PA, NP, RN or LVN signature: _____ **Clinic phone number:** _____

Please print your name: _____ **Clinic Name and Address:**_____

Return completed form via email or mail to Student Health 301 University Blvd. Galveston, TX 77555-1369, FAX 409-747-9330
Email address: stdwappt@utmb.edu. For questions please call 409-747-9508.

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