utmb Health
Student Health

UTMB Student Health
\Immunization Record-Galveston College

Name: ________________________________ **Date of Birth:** ______________ **Student ID #:** ____________________

For Currently Enrolled Students	For New Prospective/Incoming Students	Please Circle Appropriate Program:
: **Provide Initial Entering Term & School Year:** Term: Year:	**Circle Entering Term & School Year** Fall Spring Summer Year: 2012 2013 2014 2015	**Nursing Programs:** **LVN LVN to RN A.D.N. Phlebotomy** **Allied Health Programs:** **CTMT RADR RADT MRIT NMTT EMS**

Please refer to the Immunization Requirement Sheet to determine what is required.
(In order for your record to be process please complete all information above and below with supported documentation)

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: _______________

Titers may be required for some clinical sites
Please attach lab reports if these are drawn.

Measles Titer: _______________ Result: _____________

Mumps Titer: _______________ Result: _____________

Rubella Titer: _______________ Result: ____________

Tuberculin Test (PPD)
Must be within 6 months of the first day of class.

Date: _______________ Reading: __________mm Induration
If there is a history of a positive PPD, a report of a negative CXR taken after the positive PPD is required.

Positive PPD Date: __________

Chest X-Ray Date: _______________ Report:__________

INH Medication Taken: Yes No

Quantiferon - TB Gold Test Date: Result:

Varicella (Chicken pox)
Two doses of Varicella Vaccine **OR** report of a positive titer is required for all students.

#1 Date: ______________ #2 Date: ____________

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

Please attach lab report

Titer Date: _______________ Result: ____________

Hepatitis B OR Hepatitis A&B Combination
Completed series (3 doses) and positive titer. (If titer antibody is negative repeat series)

#1 Date: _____________ #2 Date: ____________

#3 Date: __________

Please attach lab report

Titer Date: Result:

#4 Date: __________ #5 Date: __________

#6 Date: __________

Titer Date: Result:

Hepatitis A&B Combination: #1 Date: __________ #2 Date: __________

#3 Date: __________

Titer Date: Result:

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

Influenza
School Year:______ Date: ____________School Year:______ Date:___________ School Year: ______ Date:_________ School Year:______ Date:__________

For Student Health Office Use Only (Not a requirement for enrollment)

Hepatitis A #1 Date: _________ Hepatitis A #2 Date: _________ Japanese Encephalitis #1 Date: ___________ Japanese Encephalitis #2 Date: _________

Rabies #1 (0) Date: Rabies #2 (7) Date: Rabies #3 (28) Date: Typhoid Date: Polio Date:

I verify that the above information is an accurate report.

MD, 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