The University of Texas Medical Branch
Student Wellness
Immunization Record

Name: ______________________ Student ID #: _______________ Date of Birth: _________

School: GC GSBS SHP SOM MD/Ph.D. SON Program: __________________
(circle one)

MMR (measles, mumps & rubella)	***OR***	**Measles**
Born in or after 1957, two doses are required, before 1957, one dose is required. #1 Date: _______________ #2 Date: _______________ **Please provide report of MMR series or individual immunizations for measles, mumps and rubella.** **Please note that report of illness DOES NOT meet the requirement for measles, mumps or rubella. You must report dates of immunization or positive titer results.**		Born in or after 1957, two doses separated by 30 days or a positive titer. #1 Date: _______________ #2 Date: _______________ Titer Date: ______________ Result: _________________ **Mumps** Born in or after 1957, one dose or a positive titer. Date: ______________ Titer Date: _____________ Result: _________________ **Rubella (All Students either Rubella or 1 MMR)** One dose or a positive titer. Date: __________________ Titer Date: Result:

Varicella (chicken pox)

Two doses, report of positive titer or report of date of illness is required for all students.

#1 Date: ______________

#2 Date: ______________

Titer Date: Result: Date of illness:

Tetanus, Diphtheria, Pertussis (Tdap) **(see immunization requirements for more information- this is an adult immunization not the childhood series)**

Tdap Date: ***Students without patient contact*** **– Tetanus/Diphtheria (Td) Date:**

Tuberculin Test A PPD reading within 6 months of enrollment is required. **Date:** __________ **Result:** _______________

Date:	**Result:**	**Date:**	**Result:**	**Date:**	**Result:**	**Date:**	**Result:**

If there is a history of a positive PPD, a report of a negative chest x-ray taken after the positive PPD is required.

Positive PPD Date: Chest X-Ray Date: Report:

Hepatitis B

Complete series (3 doses) and positive titer after the series is completed are required.

#1 Date: ____________ #2 Date: ____________ #3 Date: ____________

Titer Date: Result:

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:

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Return completed form to Student Wellness 301 University Blvd. Galveston, TX 77555-0169 FAX 409-747-9330