

**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)

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

<b>Date:</b>	<b>Result:</b>	<b>Date:</b>	<b>Result:</b>	<b>Date:</b>	<b>Result:</b>	<b>Date:</b>	<b>Result:</b>
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**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:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Return completed form to Student Wellness 301 University Blvd. Galveston, TX 77555-1105 FAX 409-747-9330**