IMMUNIZATION RECORD
The University of Texas - Houston Health Science Center

DIRECTIONS: Return this Immunization Record to Medical School Health Services. Because it may take you some time to obtain the information and signature of your physician or other health care provider, you should begin to complete this form immediately.

THIS FORM MUST BE SUBMITTED TO HEALTH SERVICES; DO NOT TAKE FORM TO REGISTRAR'S OFFICE

If you are lacking required immunizations at the time you register, the University of Texas Medical School Health Services will administer the needed vaccine(s) and you must pay for such immunizations at the time of service.

Medical School Health Services
The University of Texas-Houston Medical School
6410 Fannin, Suite 510
Houston, TX 77030

Phone Number(713)500-5171
Fax: (713)500-0605

Print or Type SCHOOL: ____________

Name ____
(Last) (First) (MI)

Date of Birth: ____________________ SS# ______________________ Registration date: _________________20 _______

Current Mailing Address: ____
Home Phone ( )______________________

DIPHTHERIA-TETANUS: Proof of a booster shot within the past 10 years is required.
Date of Diphtheria-Tetanus booster: ______________ or Tetanus Diphtheria and Pertussis Booster:__________________

HEPATITIS B: If you have received the Hepatitis B vaccine, please indicate the following:
Date(s) of all vaccines received: __________ __________ ____________
Post-vaccine antibody testing & results: __________

MEASLES: Individuals must submit one of the following:

(a) Signed physician's record documenting illness
(b) Signed physician's record documenting (2) immunizations
(c) Laboratory report of immune serum antibody titer

If none of the above are available:

(a) Two (2) Measles immunizations must be given at least 30 days apart, unless contraindicated.
Date of first immunization: _________________ Date of second immunization: ___________________

OR

(b) If one Measles immunization can be documented after 1969, a Measles serum antibody titer can be drawn to ascertain immunity, then a second Measles immunization may be omitted.
Date of first immunization: _________________ Date and result of Measles titer: __________________
Date of second Measles immunization, if necessary: __________________

MUMPS: One of the following must be submitted:

(a) Signed physician's record documenting illness
(b) Signed physician's record documenting immunization
(c) Laboratory report of immune serum antibody titer

If none of the above are available, vaccine must be given unless contraindicated.
Date of Mumps vaccine: ___________________

RUBELLA: One of the following must be submitted:

(a) Signed physician's record documenting immunization
(b) Laboratory report of immune serum antibody titer

If neither of the above is available, vaccine must be given, unless contraindicated.
Date of Rubella vaccine: ___________________

TUBERCULOSIS: Skin Test-intermediate strength (5 tu) within 12 months prior to registration is required.
Date of Skin Test: ________________________ (Old tuberculin NOT ACCEPTABLE.)
Result at 48-72 hours: ____ Negative ____ Positive ____ MM in duration
Result of Chest X-Ray if positive: ____ Normal ____ Abnormal
Did you take INH prophylaxis? ____ Yes ____ No

VARICELLA: Have you had chickenpox? _____ Yes ____ No
If no, varicella titer is required. If titer is negative, varicella vaccine series is required.
Dates of varicella vaccines: _________________ ________________

Physician/Health Care Provider Name: (Print) ____

Address: ____ Telephone: ( ) _____________
(Street) (City) (State) (Zip)

Physician/Health Care Provider's SIGNATURE: ____ Date ____________________

STUDENT SIGNATURE: I certify that, to the best of my knowledge, the above information is correct.

Signature: ____ Date ____________________