

# Immunization Requirements

Prior to Registration, all students are required to have completed the immunizations outlined below. Each student must submit written and signed documentation by a licensed healthcare provider (RN, NP, PA, or MD) verifying their vaccination status.

Accordingly, a student's written acceptance (Letter of Intent) of an offer of admissions from specific school is insufficient and incomplete unless the student also attaches his/her healthcare signed documentation of immunization compliance.

## Hepatitis B Alone or Hepatitis A&B Combo Vaccine

All students at the Health Science Center must be immunized against Hepatitis B before contact with patients or any and all other potentially contaminated materials, products, or sources. The Health Science Center will accept either the standard Hepatitis B (3 injections) or the expedited Hepatitis A&B combo vaccine series (3 injections). The Hepatitis B series can take between 4 to 6 months to complete.

Laboratory report of post-vaccine positive immune serum antibody titer for Hepatitis B will also be accepted.

## Bacterial Meningitis

Pursuant to SB 1107 recently enacted by the State of Texas, all new students enrolling in the UT Health Science Center must provide proof that the meningitis vaccination was administered at least 10 days prior to the first day of the term. Vaccinations must have been received or renewed within the last 5 years. The legislation provides two exceptions: a) students who are over 30 years of age and b) students taking 100% of classes online.

Students who qualify for the above legislative exceptions and wish to exercise same must complete a Meningitis Exemption Form. Failure to do so consistent with the noted timeframe will preclude registration.

## Tuberculosis

All students must submit one of the following. PLEASE NOTE: For International students, such healthcare services must be performed and documented by a healthcare professional licensed and practicing in the United States.

1. Proof of a TB skin test (PPD) completed within one year of enrollment, or
2. For those persons with a history of a positive skin test:
  - A. Proof of a TB evaluation conducted by a licensed healthcare provider within one year prior to enrollment is required AND
  - B. Proof of a negative chest x-ray result dated after the initial positive PPD

## Tetanus-Diphtheria (Td) or Diphtheria-Tetanus-Acellular Pertussis (TdaP)

Proof of booster shot with either the Td or TdaP within the past 10 years is required. Health care workers who have direct patient contact should get **one** dose of TdaP. A 2-year interval since the last Td is suggested but not required.

## Polio

All students under the age of 18 are required to show proof of polio vaccination.

## Measles-Mumps-Rubella

All students must submit one of the following:

1. Proof of vaccination with:
  - A. Measles - 2 vaccines required AND
  - B. Mumps & Rubella - 1 vaccine each, OR
2. MMR combo vaccine – 2 doses
3. Laboratory report of positive immune serum antibody titer for Measles, Mumps, and Rubella.

## Varicella (Chicken Pox)

All students must submit one of the following:

1. Documentation of two immunizations administered on or after the first birthday and at least 30 days apart, or
2. Documentation from a health care provider on the date of the previous disease (chicken pox or zoster), or
3. Laboratory report of positive immune serum antibody titer (IgG).

## Meningococcal conjugate vaccine quadrivalent

All students must provide proof of vaccination against meningitis. Students must have received the vaccine within five years prior to enrollment. Certain exceptions may apply. Please see:

The Board of Regents may require immunizations against additional diseases for some students. Further immunizations may be required by the Board of Regents in times of emergency or epidemic. The cost of all immunizations will be the responsibility of the student and/or dependent.

## STUDENT IMMUNIZATION RECORD

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(Print or type) Last First MI

HSC Badge # \_\_\_\_\_ Phone number: \_\_\_\_\_

**SCHOOL/PROGRAM ENTERING:**

School of Medicine	School of Dental	School of Health Professions	Nursing School	Graduate School	Non-Degree Student
<input type="checkbox"/> Deaf Education <input type="checkbox"/> Medicine	<input type="checkbox"/> Dental Hygiene <input type="checkbox"/> Adv. Dental School <input type="checkbox"/> Dental School	<input type="checkbox"/> Clinical Laboratory Sciences <input type="checkbox"/> Emergency Health Sciences <input type="checkbox"/> Physician Assistant Studies <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Respiratory Care	<input type="checkbox"/> Graduate <input type="checkbox"/> Accelerated <input type="checkbox"/> Traditional	<input type="checkbox"/> Biomedical Engineering <input type="checkbox"/> Cellular & Structural Biology <input type="checkbox"/> Clinical Investigation <input type="checkbox"/> Integrated Multidisciplinary Graduate Program (IMGP) <input type="checkbox"/> Molecular Medicine <input type="checkbox"/> Pharm. D. <input type="checkbox"/> Physiology	<input type="checkbox"/> Non-Degree

**IMMUNIZATION HISTORY:** This section is to be completed by a MD, P A, N P, D O and signed on the bottom of this card.

**HEPATITIS B ONLY OR HEPATITIS A&B COMBO VACCINE:**

Date: 1) \_\_\_\_\_ Date: 2) \_\_\_\_\_ Date: 3) \_\_\_\_\_

**AND**

Hepatitis B Antibody Titer: Date: \_\_\_\_\_ Immune \_\_\_\_\_ Not Immune \_\_\_\_\_ Value: \_\_\_\_\_

**TUBERCULOSIS:**

**1<sup>st</sup> PPD test**

**TST:** Date Placed \_\_\_\_\_ Time \_\_\_\_\_ Date Read \_\_\_\_\_ Time \_\_\_\_\_ **Results:** \_\_\_\_\_ mm \_\_\_\_\_ Positive \_\_\_\_\_ Negative

**2<sup>nd</sup> PPD test**

**TST:** Date Placed \_\_\_\_\_ Time \_\_\_\_\_ Date Read \_\_\_\_\_ Time \_\_\_\_\_ **Results:** \_\_\_\_\_ mm \_\_\_\_\_ Positive \_\_\_\_\_ Negative

**- OR -**

**BAMT:** Date: \_\_\_\_\_ **Results:** \_\_\_\_\_ Negative \_\_\_\_\_ Positive

**IF POSITIVE READING**

CXR results: \_\_\_\_\_ date: \_\_\_\_\_ TB screening: \_\_\_\_\_ Date: \_\_\_\_\_

**VARICELLA (CHICKEN POX):**

1st immunization Date: \_\_\_\_\_ 2<sup>nd</sup> immunization Date: \_\_\_\_\_

**- OR -**

Date of disease (month & year): \_\_\_\_\_

**- OR -**

Varicella Titer: Date: \_\_\_\_\_ Immune \_\_\_\_\_ Not Immune \_\_\_\_\_ Value: \_\_\_\_\_

**MUMPS, MEASLES (RUBEOLA), RUBELLA:**

1<sup>st</sup> immunization Date: \_\_\_\_\_ 2<sup>nd</sup> immunization Date: \_\_\_\_\_

**- OR -**

Mumps Titer: Date: \_\_\_\_\_ Immune \_\_\_\_\_ Not Immune \_\_\_\_\_ Value: \_\_\_\_\_

Measles Titer: Date: \_\_\_\_\_ Immune \_\_\_\_\_ Not Immune \_\_\_\_\_ Value: \_\_\_\_\_

Rubella Titer: Date: \_\_\_\_\_ Immune \_\_\_\_\_ Not Immune \_\_\_\_\_ Value: \_\_\_\_\_

**DIPHTHERIA-TETANUS (Td) OR DT PERTUSSIS (Tdap):**

**FLU VACCINE:**

**MENINGITIS (Age 22 and less):**

Date of booster: \_\_\_\_\_ Date of vaccination: \_\_\_\_\_ Date of vaccination: \_\_\_\_\_

Provider Name (Print) \_\_\_\_\_ Title (M.D., D.O., P.A., N.P.) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_ Daytime Phone (\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_  
Street City/State Zip