

***UT-Houston Medical School Health Service***  
***6410 Fannin Suite 510***  
***Phone: (713) 500-5171***  
***Fax: (713) 500-0605***

## **CERTIFICATION OF IMMUNIZATION**

**Please return this form to UT-Houston Medical School Health Service at the fax number noted above. Do not send it to the Registrar's Office and DO NOT MAIL FORM.**

You will be cleared to register only after you meet all immunization requirements. Schools at the University of Texas-Houston Health Science Center vary in immunization requirements. Please refer to the attached table to determine your specific requirements.

Please have your health care provider complete this certification of immunization. If you are a prospective or current student at the UT Houston schools and need immunizations, you are welcome to use the UT-Houston Medical School Health Services – no appointment required (8:30 am to 5:00 pm M-F).

**Hepatitis B**  
**Menigococcal Vaccine**  
**MMR (measles mumps rubella)**

**Diphtheria/tetanus**  
**Varicella**  
**PPD Skin Test**

**\*SEE ALSO ATTACHED IMPORTANT INFORMATION ABOUT BACTERIAL MENINGITIS.**  
**NOTE:** While this vaccination is not required, UT-Houston is required to provide you with the attached information. By signing this certification of Immunization form, you acknowledge that you have received and read this information about Bacterial Meningitis.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Last Name

\_\_\_\_\_  
First Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Social Security #

### **Current Address**

\_\_\_\_\_  
Street & Apt. #

\_\_\_\_\_  
City State Zip Code Country

Telephone ( \_\_\_\_\_ ) \_\_\_\_\_

Please check which school you will be attending:

SHIS

Dental

GSBS

Medical

Nursing

Public Health

<b>REQUIRED IMMUNIZATIONS</b>	<b>MINIMUM REQUIREMENT</b>
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<b>Tetanus/Diphtheria</b>	One dose within the past 10 years
<b>Measles (Rubeola)</b>	Two (2) doses of measles vaccine if born after January 1, 1957 administered on or after your first birthday and at least 30 days apart; <b>or</b> evidence of immunity to measles by presenting a physician documented history of the disease <b>or</b> lab report of positive rubeola titer
<b>Mumps</b>	One dose of mumps vaccine administered on or after first birthday; <b>or</b> evidence of immunity to mumps by presenting a physician documented history of the disease <b>or</b> lab report of positive mumps titer
<b>German Measles (Rubella)</b>	One dose of rubella vaccine administered on or after first birthday; <b>or</b> immunity to rubella by presenting a lab report of positive rubella rubella titer.
<b>PPD (TB) Skin Test</b>	Within the past 12 months, even for those who have received BCG vaccine as a child. If PPD skin test is positive, a chest x-ray documenting no active tuberculosis must be submitted with immunization form
<b>Hepatitis B Series</b>	Three-dose series (second dose one month and third dose six months after first dose) <b>or</b> a lab report of positive hepatitis surface antibody titer. Must be vaccinated to most current status possible prior to registering for classes.
<b>Varicella (Chickenpox) Series</b>	Two-dose series (second dose one month after first dose) <b>or</b> a physician-validated history of the disease <b>or</b> lab report of positive varicella titer.

<b>IMMUNIZATION REQUIREMENTS FOR EACH UT-HSC SCHOOL</b>
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	Measles	Mumps	Rubella	Hepatitis B	Tetanus-Diphtheria	PPD	Varicella
School of Health Information Sciences						R	x
Dental School	R	R	R	R	R	R	R
Nursing School	R	R	R	R	R	R	R
Medical School	R	R	R	R	R	R	R
GSBS	R	R	R	x	R	R	x
School of Public Health	R	R	R	x	R	R	x

**Key: R= Required      x= Required if exposed to human blood/body fluids**

**REQUIRED IMMUNIZATIONS**

DATE (month/day/year)

1. **Tetanus/diphtheria** (within past 10 years) \_\_\_\_\_

2. **Measles (rubeola)** vaccine: #1 \_\_\_\_\_

(2 are required if born after January 1, 1957) *or* #2 \_\_\_\_\_

Rubeola disease (documented by health care provider) *or* \_\_\_\_\_

Positive rubeola titer (attach lab report) \_\_\_\_\_

3. **Mumps** vaccine *or* \_\_\_\_\_

Mumps disease (documented by health care provider) *or* \_\_\_\_\_

Positive mumps titer (attach lab report) \_\_\_\_\_

4. **Rubella** vaccine *or* \_\_\_\_\_

Positive rubella titer (attach lab report) \_\_\_\_\_

5. **Hepatitis B** vaccine series (3 injections) *or* #1 \_\_\_\_\_

#2 \_\_\_\_\_

#3 \_\_\_\_\_

Positive hepatitis B surface antibody titer (attach lab report) \_\_\_\_\_

6. **Varicella** vaccine series (2 injections) *or* #1 \_\_\_\_\_

#2 \_\_\_\_\_

Chicken pox disease (documented by health care provider) *or* \_\_\_\_\_

Positive varicella titer (attach lab report) \_\_\_\_\_

7. **Tuberculin skin test** (PPD) (required within the last 12 months, even if you have received BCG vaccine as a child)

Date: \_\_\_\_\_ Result: \_\_\_\_\_ negative \_\_\_\_\_ positive (measurement \_\_\_\_\_ x \_\_\_\_\_ mm if available)

If positive, did you take INH prophylaxis? \_\_\_\_\_ Yes \_\_\_\_\_ No

Chest x-ray findings if PPD is positive (attach x-ray report)

Date of chest x-ray: \_\_\_\_\_

Result: ( ) No evidence of active tuberculosis

( ) X-ray consistent with active tuberculosis

( ) Abnormal x-ray, but not due to tuberculosis

Health Care Provider Signature

Address

City

State

Zip Code

Phone Number

Fax Number