**Addendum A**  
Texas State University  
College of Health Professions  
Immunizations and Tests Form

Student's Name: ___________________________  TXSTATE ID#: A0 __________ Date of Birth: _______________

### Measles/Mumps/Rubella Vaccine
- **One of the following is required:**
  - A. Two doses of measles vaccine at least 28 days apart  
    Administration Date #1 __________ Administration Date #2 __________  
    (mm/dd/yy) (mm/dd/yy)
  - OR
  - B. Serologic test positive for measles antibody  
    Date ___________________ Circle Results: Positive  Negative  
    (mm/dd/yy)

### Hepatitis B - must show proof of:
- **One of the following is required:**
  - A. Three doses of vaccine administered over a period of at least 6 months. Initial vaccine followed by 1 and 6 months vaccines respectively.  
    Administration Date #1 __________ Administration Date #2 __________ Administration Date #3 __________  
    (mm/dd/yy) (mm/dd/yy) (mm/dd/yy)
    **Note: Third vaccine must be at least 6 months from initial vaccine**
  - OR
  - B. Serologic test positive for Hepatitis B antibody  
    Date ___________________ Circle Results: Positive  Negative  
    (mm/dd/yy)

### Varicella (Chicken Pox) - One of the following is required:
- A. Two doses of Varicella vaccine administered 4-8 weeks apart  
  Administration Date #1 __________ Administration Date #2 __________  
  (mm/dd/yy) (mm/dd/yy)
- OR
- B. Serologic test positive for Varicella antibody  
  Date ___________________ Circle Results: Positive  Negative  
  (mm/dd/yy)

### Tetanus (TDAP):**  
-Tdap protects against Tetanus, Diphtheria, and Pertussis.  
This vaccine is to be given every ten years. (Td is not acceptable)  
Date ___________________________  
(mm/dd/yy)

### Meningococcal Vaccine:  
Evidence of vaccination if student is 21 years or younger on the first day of the semester.  
Date ___________________________  
(mm/dd/yy)
**Tuberculosis (TB) Testing:**

**2 Options**

**A. Two Step Tuberculin Skin Test**
- First test with reading must be done prior to clinical assignment.
- Second administration (with reading) must be 7 or more days from the first administration.

**OR**

**B. TB Blood test**
*Use blood test if had prior positive blood test or if received BCG vaccine.*

Attention: Healthcare provider

If a student tests positive for TB, include a synopsis of their treatment plan with this form. The following are suggested minimum requirements to be included in this plan:
- Blood test (T-Spot or QuantiFERon) if the two step skin test was positive
- Chest X-ray to be completed if positive blood test
- Current completed Tuberculosis Assessment and Symptoms Checklist. Attach the completed checklist (with student's name and DOB) as page 3 of this form.

<table>
<thead>
<tr>
<th>First Administration Date</th>
<th>Date Read</th>
<th>Circle Results: Positive Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Second Administration Date</td>
<td>Date Read</td>
<td>Circle Results: Positive Negative</td>
</tr>
</tbody>
</table>

Circle type of test: T-Spot QuantiFERon

Date (mm/dd/yy) Circle Results: Positive Negative

Treatment plan for (Student's Name):

*Validates all information above.*

**Flu Shot**

Evidence of vaccination.

Date _____________________________(mm/dd/yy)

**Physician or Approved Licensed Healthcare Provider Information:**

Printed Name

Address

Signature of Physician or Licensed Healthcare Provider* Date

* Validates all information above.