

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:	
<p>A. Two doses of measles vaccine at least 28 days apart</p> <p>OR</p>	<p>Administration Date #1 _____ Administration Date #2 _____ (mm/dd/yy) (mm/dd/yy)</p>
<p>B. Serologic test positive for measles antibody</p>	<p>Date _____ Circle Results: Positive Negative (mm/dd/yy)</p>
Hepatitis B - must show proof of:	
<p>A. Three doses of vaccine administered over a period of at least 6 months. Initial vaccine followed by 1 and 6 months vaccines respectively.</p> <p>Note: Third vaccine must be at least 6 months from initial vaccine</p> <p>OR</p>	<p>Administration Date #1 _____ (mm/dd/yy)</p> <p>Administration Date #2 _____ (mm/dd/yy)</p> <p>Administration Date #3 _____ (mm/dd/yy)</p>
<p>B. Serologic test positive for Hepatitis B antibody.</p>	<p>Date _____ Circle Results: Positive Negative (mm/dd/yy)</p>
Varicella (Chicken Pox) - One of the following is required:	
<p>A. Two doses of Varicella vaccine administered 4-8 weeks apart</p> <p>OR</p>	<p>Administration Date #1 _____ (mm/dd/yy)</p> <p>Administration Date #2 _____ (mm/dd/yy)</p>
<p>B. Serologic test positive for Varicella antibody</p>	<p>Date _____ Circle Results: Positive Negative (mm/dd/yy)</p>
Tetanus (TDAP): <u>Tdap protects against Tetanus, Diphtheria, and Pertussis.</u> This vaccine is to be given every ten years. (Td is not acceptable)	
<p>Date _____ (mm/dd/yy)</p>	
Meningococcal Vaccine: Evidence of vaccination if student is 21 years or younger on the first day of the semester.	
<p>Date _____ (mm/dd/yy)</p>	

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.

First Administration Date _____

Date Read _____ Circle Results: Positive Negative

Second Administration Date _____
(minimum of 7 days from first administration)

Date Read _____ Circle Results: Positive Negative

Circle type of test: T-Spot QuantiFERon

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

Treatment plan for (Student's Name): _____

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.