Addendum B
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 **OR**	Administration Date #1 _____ (mm/dd/yy) Administration Date #2 _____ (mm/dd/yy)
B. Serologic test positive for measles antibody	Date_____ (mm/dd/yy) Circle Results: Positive Negative
Hepatitis B - must show proof of:	
A. Three doses of vaccine administered over a period of at least 6 months. Initial vaccine followed by 1 and 6 months vaccines respectively. **Note: Third vaccine must be at least 6 months from initial vaccine** **OR**	Administration Date #1 _____ (mm/dd/yy) Administration Date #2 _____ (mm/dd/yy) Administration Date #3 _____ (mm/dd/yy)
B. Serologic test positive for Hepatitis B antibody.	Date _____ (mm/dd/yy) Circle Results: Positive Negative
Varicella (Chicken Pox) - One of the following is required: **A.** Two doses of Varicella vaccine administered 4-8 weeks apart **OR**	Administration Date #1 _____ (mm/dd/yy) Administration Date #2 _____ (mm/dd/yy)
B. Serologic test positive for Varicella antibody	Date _____ (mm/dd/yy) Circle Results: Positive Negative

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.	**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.**