TTUHSC School of Medicine Immunization Form for Visiting Students

HEALTH STATEMENT FOR VISITING MEDICAL STUDENTS
TO BE COMPLETED BY A HEALTH PROVIDER OR APPROPRIATE SCHOOL OFFICIAL

In order to protect the health of our medical students and the health of the patients with whom they come in contact, the School of Medicine requires all visiting students to provide documentation of several immunizations as well as the results of serological titers to determine whether or not they are actually immune to certain diseases. **This form must be verified and signed by your school’s official or a health care provider.**

- Copies of lab reports, immunizations and/or health records must be provided.
- All results must be in English from a U.S. lab.

1. **Varicella (Chicken Pox):** Documentation of 2 Varicella vaccine doses
   - Dose #1 date ____________ Dose #2 date ____________
   OR Documented Varicella immunity-titer -- Date of Test: _______________ (Attach Report)
   OR Physician documented history of disease -- Date ____________

2. **Measles, Mumps, and Rubella (MMR):** Documentation of 2 MMR vaccine doses
   - MMR #1-Date __________ MMR# 2-Date __________
   OR MMR titer: Date of test ____________ (Attach Report)

3. **Tuberculosis 2 –Step TB skin test (if you have not had a TB test within the last 12 months)**
   - 1st test Date: ______ Result: _____ mm (if you have had a TB test within 12 months)
   - 2nd test Date: ______ Result: _____ mm
   OR Chest X-ray if (+) TB skin test Date: ____________ Result: ______________
   Chest X-Ray must be within 3 months if TB skin test is positive. (Attach Report)

4. **Hepatitis B series:** Documentation of 3 Hepatitis B vaccine doses
   - Dose#1 date_______ Dose #2 date_______ Dose #3 date_______
   OR Hepatitis B Surface Antibody Date of test: ____________ (Attach Report)

5. **Tetanus/diphtheria (Td):** Tetanus Diphtheria booster (required within past 10 years)
   - Td Date: ____________ (Tdap will suffice)

6. **Tdap (Tetanus, Diphtheria, and Acellular Pertussis):** Adult (one time dose)
   - Tdap date: __________

7. **Meningococcal (MCV):** Required for adults 29 years of age or younger (within the last 5 years)
   - MCV date: ____________

Your application is not complete until all above requirements are completed. You may **NOT** begin your training at Texas Tech Health Sciences Center School of Medicine until all requirements are completed.

**I certify that the above statements are true:**

Printed name of School Official: ____________________________

Signature of School Official: ____________________________

Date: _________________