R#________________NAME____________________________
Email:__________________________Phone number:__________________ Program:_**DPT, MP, BSML, PA**

TTUHSC SHP Immunizations

Copies of lab reports, immunizations and/or health records must be provided.

1. **Varicella (Chicken Pox)** Positive Varicella Titer (blood test) **IgG** Date of Test: _______________ (Attach Report)

   TTUHSC does not accept vaccine

2. **Measles, Mumps, and Rubella (MMR)** Positive MMR titer (blood test) **IgG** Date of Test: ________________ (Attach Report)

   TTUHSC does not accept vaccine

3. **Tuberculosis:** **2 –STEP TB skin test (within the past 3 months)**

   1st test Date: ______ Result: _____ mm
   2nd test Date: ______ Result: _____ mm
   If positive on TST
   Negative Chest X-Ray if (+) TST Date: __________ Result: _________

   Chest X-Ray must be no older than 1 year, if TB skin test is positive.
   (Attach Report)

   TTUHSC will also accept IGRA (T-SPOT or quantiFERON) testing in place of a TB test (within the past 3 months)

   Date: ___________ Results: _____________

> **www.nationaltbcenter.edu**
>
> **Visit 1, day 1: Place the 1st TST and have the employee return in 7 days for the test to be read.**
>
> **Visit 2, day 7: Place 2nd TST on all employees/volunteers whose 1st test is negative at 7 days.**
>
> **Visit 3, day 9 or 10: Read the 2nd test at 48-72 hours.**
> **There are different ways of performing the 2 Step TB, we accept any of them**

4. **Hepatitis B :** Positive Hepatitis B titer (**Surface Antibody**): Date of Test: __________ (Attach Report)

   TTUHSC does not accept vaccine

5. **Tetanus/diphtheria (Td): Tetanus Diphtheria booster (must be within past 10 years)**

   Td Date: _____________ (Tdap will suffice)

6. **Tdap (Tetanus, Diphtheria, and Acellular Pertussis): One time Adult Dose (these are only good for 10 years, must be good for your entire length of enrollment)**

   Tdap date: ___________

7. **Meningococcal Vaccine (MCV): Adults 22 and younger (vaccine within the last 5 years)**

   MCV date: ______________ circle exemption (age, online)

8. **Influenza Vaccine:** Influenza date:_____________ (must be administered during FLU season September- March)

TTUHSC strongly recommends that you be vaccinated for COVID-19. If you have received the COVID-19 vaccine, please document below:

9. **Covid- 19 Vaccine:** Documentation of Primary Monovalent Series Dose #1 and Dose #2 – OR – Bivalent Dose #1

   Dose#1 Date_____________Dose#2 Date_______________Booster Date___________

**COVID-19 VACCINATION MAY BE MANDATORY AT SOME CLINICAL SITES. AT THIS TIME, TTUHSC DOES NOT REQUIRE YOU TO DISCLOSE WHETHER OR NOT YOU HAVE RECEIVED THE COVID-19 VACCINE. HOWEVER, FOR THOSE WHO DO NOT RECEIVE THE VACCINE OR OBTAIN AN APPROVED COVID-19 VACCINE WAIVER, IF APPLICABLE, YOUR ABILITY TO OBTAIN REQUIRED CLINICAL HOURS NECESSARY FOR PROGRAM COMPLETION MAY BE IMPACTED. FOR THOSE WHO WISH TO NOT DISCLOSE, IT WILL BE CONSIDERED THAT YOU HAVE NOT RECEIVED THE VACCINE FOR THE PURPOSES OF ADHERING TO CLINICAL SITE REQUIREMENTS.*

This completed form and supporting documentation should be forwarded as soon as possible to:

Office of Institutional Health- TTUHSC
3601 4th st MS 8150
SHP Immunization Coordinator
Lubbock TX 79430
fax 806-743-2056 or email to
Mecole.campbell@ttuhsc.edu
(806-743-7455)