

R# \_\_\_\_\_ NAME \_\_\_\_\_

Email: \_\_\_\_\_ @ttuhsc.edu Phone number: \_\_\_\_\_ Program: OTD, MAT, SLHS (SLHS, SLP, AUD)

## TTUHSC SHP Immunizations

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

1. **Varicella (Chicken Pox): Documentation of 2 Varicella vaccine doses**

Dose #1 date \_\_\_\_\_ Dose #2 date \_\_\_\_\_

**OR**

Documented Varicella immunity-titer (blood test)

**1<sup>st</sup> test** Date: \_\_\_\_\_ Result: \_\_\_\_\_ mm

**2<sup>nd</sup> 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: \_\_\_\_\_

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 (blood test) Date of Test: \_\_\_\_\_ (Attach Report)

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): Adult Dose**

Tdap date: \_\_\_\_\_

7. **Influenza Vaccine:**

Influenza date: \_\_\_\_\_ (must be during FLU season October-Mar)

8. **Meningitis Vaccine:**

\_\_\_\_\_ **Adults 22 and younger** (vaccine within the last 5 years)

**\*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 M