

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)

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

**(TTUHSC does not accept history of disease)**

2. **Measles, Mumps, and Rubella (MMR):**

**Documentation of 2 MMR vaccine doses**

MMR #1-Date \_\_\_\_\_ MMR# 2-Date \_\_\_\_\_

**OR**

MMR titer (blood): Date of test \_\_\_\_\_ (Attach Report)

3. **Tuberculosis:**

**2-STEP TB skin test (within the last 3 months)**

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: \_\_\_\_\_

**Visit 1, day 1:** Place the 1<sup>st</sup> TST and have the employee return in 7 days for the test to be read.

**Visit 2, day 7:** Place 2<sup>nd</sup> TST on all employees/volunteers whose 1<sup>st</sup> test is negative at 7 days.

**Visit 3, day 9 or 10:** Read the 2<sup>nd</sup> test at 48-72 hours.

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 administered during FLU season September-March)

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 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  
Email: Mecole.Campbell@ttuhsc.edu 806-743-7455**