

Occupational Health Program

ELECTIVE MEDICAL STUDENT IMMUNIZATION RECORD

Start date: _____ End date: _____

Name _____ Date of Birth _____ Phone _____

Address _____ Email _____

Complete form and attach supporting documentation

	DATE
A. Tetanus-Diphtheria 1. _____ Completed primary series of tetanus-diphtheria immunizations. 2. _____ Received tetanus-diphtheria booster within the last 10 years. (attach record)	_____ _____
B. M.M.R. (Measles, Mumps, Rubella) (please document each dose) 1. _____ Dose 1: Immunized at 12 months or after. (attach record) 2. _____ Dose 2: Immunized after 1980. (attach record)	_____ _____
C. Measles (Rubeola) - If given instead of M.M.R. check appropriate item 1. _____ Born before 1957, considered immune. 2. _____ Serologic proof of immunity. (attach record) 3. _____ Immunized with live virus, twice , at least once after 1980. (attach records)	_____ _____ _____
D. Rubella - If given instead of M.M.R. check appropriate item 1. _____ Serologic proof of immunity. (attach record) 2. _____ One dose of vaccine on or after 1st birthday. (attach record)	_____ _____
E. Mumps - If given instead of M.M.R. check appropriate item 1. _____ Born before 1957, considered immune. 2. _____ Serologic proof of immunity. (attach record) 3. _____ One dose of vaccine on or after 1st birthday. (attach record)	_____ _____ _____
F. Varicella (Chicken Pox) 1. _____ Had disease (complete Varicella record form) 2. _____ Serologic proof of immunity. (attach record) 3. _____ Immunization (2 doses) (attach record)	_____ _____ _____
G. Tuberculosis 1. _____ PPD (Mantoux) test within the past year. (Tine or Monovac not acceptable) Give date and test result. _____ Millimeter 2. _____ Had BCG vaccine. If yes, PPD still has to be done. 3. _____ If ever positive PPD, (greater than 10 mm induration) chest x-ray required. Give date and result of chest x-ray. _____ Positive _____ Negative	_____ _____ _____ _____
H. Hepatitis B -give dates for all administered shots 1. _____ Serologic proof of immunity. (attach record) 2. _____ Immunization (at least 3 doses and attach records)	_____ _____ _____

Healthcare Provider Signature: _____ Date: _____

Healthcare Provider Name (please print): _____

Address: _____

Phone: () _____

PLEASE RETURN THIS FORM (via facsimile or mail) TO:

Office of the Registrar – Elective Medical Student Program
 One Baylor Plaza, Mailstop: BCM-365
 Houston, TX 77030

713-798-4466
 713-798-6815 (confidential fax)