

UT SOUTHWESTERN MEDICAL CENTER
AT DALLAS
Student Health Services

Immunization History Form

Name: _____ Date of Birth: _____

Student ID #: _____

Telephone Numbers: (Home): _____ (Mobile): _____ (Work): _____

Enrolled School (Medical, Graduate, or Allied Health): _____

Program if applicable (For example - Physician Assistant, Clinical Psychology, etc.): _____

Required Immunizations:

Immunization	Date	Immune Titer (Must attach a copy of titer)
(1). Tetanus/Diphtheria/Pertussis (Tdap)	#1 ___/___/___	
(2). Tetanus toxoid (Td)	#1 ___/___/___	
(3). MMR	#1 ___/___/___ #2 ___/___/___	
(4). Measles (Rubeola)	#1 ___/___/___ #2 ___/___/___	___/___/___
(5). Mumps	#1 ___/___/___	___/___/___
(6). Rubella	#1 ___/___/___	___/___/___
(7). Hepatitis B	#1 ___/___/___ #2 ___/___/___ #3 ___/___/___	___/___/___
(8). Varicella (Chicken Pox):	#1 ___/___/___ #2 ___/___/___	___/___/___

History of Disease: ___/___/___

(9). Tuberculin skin test (ppd) Date Placed: ___/___/___ Date Read: ___/___/___

Results: _____ millimeters of induration: _____

OR

History of a positive reading Date ___/___/___ millimeters of induration: _____

Chest x-ray results (Must include a copy of radiology report) Date ___/___/___ Results: _____

Verification of Information:

Signature of Health Care Provider: _____

Clinic or Office Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone #: _____ Fax# _____