

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)

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: _____

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.

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 (required 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: _____ (required 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 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**