



TEXAS A&M

HEALTH SCIENCE CENTER

IMMUNIZATION RECORD

Please print or type in the requested information. Submit this form to the College of Nursing by July 1, 2008. Keep a copy for your records.

| | | |
|---|------------------|----------------------|
| Last Name _____ | First Name _____ | Middle Initial _____ |
| Nursing Program (circle one): Generic Accelerated RN to BSN | | |
| UIN _____ | Birthdate _____ | |

| VACCINE | DATE EACH DOSE WAS GIVEN | | | | |
|--|--------------------------|-----|-----|-----|---------|
| | 1ST | 2ND | 3RD | 4TH | Booster |
| Diphtheria, Tetanus, Pertussis (Td, Tdap, DTP) 1 dose with TD booster every 10 years | | | | | |
| Measles, Mumps, Rubella (MMR) 1 or 2 doses for those under age 50; 1 dose for those over 50 Or positive titer _____ (verify by initials) | | | | | |
| Varicella (Chickenpox) 1 or 2 doses (depending on age) If you have had the chickenpox disease, provide the year, if known: _____ (vaccine not required) | | | | | |
| Hepatitis A (Hep A) 2 doses, (0, 6 - 18 months after first dose) | | | | | |
| Hepatitis B (Hep B) 3 doses (0, 1 - 2 months after first dose, 4 - 6 months after 2nd dose) Or positive titer _____ (verify by initials) | | | | | |

For information on immunization recommendations from the Centers for Disease Control, go to: <http://www.cdc.gov/vaccines/>

| | | |
|--|--|---|
| TB Skin Test List most recent date and reading | Date <input type="checkbox"/> Positive | Reading <input type="checkbox"/> Negative |
| If PPD reading is positive, chest x-ray is required subsequent to positive PPD result. Please provide copy of x-ray report or other medical documentation. Date of x-ray: | | |

This form is complete and accurate to the best of my knowledge.

| | |
|-----------------|-------------------|
| SIGNATURE _____ | DATE SIGNED _____ |
|-----------------|-------------------|

FOR OFFICE USE ONLY

Entered by: _____ Date: _____ Comments: _____
 Reviewed by: _____ Date: _____ Comments: _____