Occupational Health Program
Student Health Requirement Form

Please review and complete this form. You may consult with your primary care physician to complete it. Immunization requirements are detailed below as per Texas Department of State Health Services, OSHA Policy, BSW policy and CDC recommendations.

Name:		DOB:	
	Last First MI		
Address:			
	Street City State Zip		
Cell/Home Phone:			
Primary Email:			
Student ID:			

Vaccines	Date Received	For Office Use Only	Attached Records
MMR (Measles, Mumps, and Rubella)	2 doses of MMR vaccine, OR 2 doses of Measles vaccine, 2 doses of Mumps vaccine, 1 dose of Rubella vaccine, OR serologic proof of immunity for Measles, Mumps and/or Rubella (Choose only one option)		
Measles	Measles Dose 1		☐
	Measles Dose 2		
	Serologic Immunity (IgG antibody titer)		
Mumps	Mumps 1		☐
	Mumps 2		
	Serologic Immunity (IgG antibody titer)		
Rubella 1 dose of vaccine or positive serology	Rubella Vaccine		☐
	Serologic Immunity (IgG antibody titer)		
Varicella	2 doses of vaccine or positive serology		
Varicella	Varicella 1		☐
	Varicella 2		
	Serologic Immunity (IgG antibody titer)		

Name: _____ Date of birth: _____
(Last, First, MI) (mm/dd/yyyy)

Vaccines		Date Received	For Office Use Only	Attached Records
Tdap	1 adult dose of adult Tdap. If last Tdap is more than 10 years old, provide dates of last Td and Tdap			
Tdap Tetanus -diphtheria-pertussis	Tdap			☐
	Td Vaccine (if more than 10 years since last Tdap)			
Meningitis	Within last 5 years or age > 22 at the time of matriculation			
Meningitis (MenACWY or MCV4)	Within last 5 years			☐
	Age > 22			
Influenza	1 dose annually each fall			
Influenza	Influenza vaccine			☐
COVID – 19	2 doses of Pfizer-BioNTech, Moderna, or Novavax vaccine or 1 dose of J&J vaccine			
COVID – 19	COVID – 19 # 1			☐
	Company/Trade name			
	COVID – 19 # 2			
	Company/Trade name			
	COVID – 19 Booster			
	Company/Trade name			

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Vaccines	Date Received	For Office Use Only	Attached Records

Hepatitis B	3 doses of Engerix-B, PreHevbrio, Recombivax or Twinrix vaccines OR, 2 doses of Heplisav-B vaccine followed by a Quantitative Hepatitis B Surface Antibody test drawn 4-8 weeks after last vaccine dose. A test titer ≥ 10 mIU/mL is positive for immunity. If the test results are negative, repeat another Hepatitis B vaccine series followed by a repeat test titer.			
Hepatitis B	Hepatitis B 1			☐
	Hepatitis B 2			
	Hepatitis B 3			
	Antibody Test			
Repeat Hepatitis B *Only if no response to primary series*	Hepatitis B 4			☐
	Hepatitis B 5			
	Hepatitis B 6			
	Antibody Test			
Hepatitis B Non-responder	For Hepatitis B non-responder (negative antibody test after primary repeat vaccine series), please notify your treating provider in case of an exposure to blood or body fluid.			

Name: _____ Date of birth: _____
(Last, First, MI) (mm/dd/yyyy)

Tuberculosis (TB) Screening History					
		Date Placed	Date Read	Results	Interpretation (circle one)
Tuberculosis	TB 1			____mm	Positive Negative
	TB 2			____mm	Positive Negative
			Date	Results (circle one)	
T-spots or QuantiFERON TB Gold blood test for tuberculosis	QuantiFERON TB Gold or T-Spot (Interferon Gamma Releasing Assay)			Positive Negative Indeterminate	
	QuantiFERON TB Gold or T-Spot (Interferon Gamma Releasing Assay)			Positive Negative Indeterminate	
Use additional rows if needed					

Only for History of Positive TB skin test or Blood Test

If you were diagnosed before with latent TB, please provide documentation for treatment if completed. If not, please provide documentation of the last chest x-ray and last annual TB symptom questionnaire.

For history of active TB, please provide clearance note from primary care physician showing completion of anti-tuberculosis medication and clearance from the disease.

Tuberculosis (TB) Screening – Students should provide proof of a negative TB skin test performed within the last 3 months or a negative TB blood test (IGRA) performed within the last 6 months. If you have a history of positive TST (PPD) $\geq$ 10mm or a positive IGRA blood test, please supply information regarding any evaluation and/or treatment above.

_____ _____
Occupational Health Program Staff Signature Date