



Occupational Health Program

INCOMING STUDENT IMMUNIZATION RECORD

Name _____ Date of Birth _____ Phone _____

Address _____ Email _____

Complete form and attach supporting documentation. Please review Immunization Requirement form for detailed information on vaccine requirements.

	DATE
A. Tetanus-Diphtheria-Pertussis (Tdap)- Td is not acceptable 1. _____ Tdap 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 of age or after (attach record) 2. _____ Dose 2: Immunized at least 1 month after dose 1 (attach record)	_____ _____
C. Measles (Rubeola) - If given instead of M.M.R. check appropriate item 1. _____ Serologic proof of immunity (attach record). Or, 2. _____ Two doses of vaccine (attach record)	_____ _____
D. Mumps - If given instead of M.M.R. check appropriate item 1. _____ Serologic proof of immunity (attach record). Or, 2. _____ Two doses of vaccine (attach record)	_____ _____
E. Rubella - If given instead of M.M.R. check appropriate item 1. _____ Serologic proof of immunity (attach record). Or, 2. _____ Two doses of vaccine (attach record)	_____ _____
F. Varicella (Chickenpox)- History of disease is not acceptable 1. _____ Serologic proof of immunity (attach record). Or, 2. _____ Two doses of vaccine (attach record)	_____ _____
G. Tuberculosis 1. _____ TB blood test done within 6 month prior to your start date 2. _____ Had BCG vaccine. If yes, TB blood test still has to be done. 3. _____ If ever positive TB blood test, provide record. Chest x-ray done within last year is required. Provide copy of x-ray report.	_____
H. Hepatitis B -give dates for all administered shots 1. _____ Serologic proof of immunity (attach record). Or, 2. _____ Immunization (at least 3 doses of non-adjuvanted vaccine or 2 doses of adjuvanted vaccine. Attach records)	_____ _____ _____
I. Meningitis 1. _____ Immunization within the last 5 years (from matriculation date). Or, 2. _____ Age > 22 at time of matriculation	_____ _____
J. OHP Forms 1. _____ Acknowledgment of Receipt of Privacy Notice. The "HIPAA" form. All students. 2. _____ TB Respirator Questionnaire. MD, PA, GPNA, genetic counseling, O&P students only.	_____

Please Return This Form Along With Records By Uploading To: <https://hipaa.iotform.com/223406673263051>

Alternatively, records can be mailed to:
 Occupational Health Program, Baylor College of Medicine
 1 Baylor Plaza- (Mail Stop BCM608), Houston, TX 77030
 713-798-7880