2024

Baylor College of Medicine

Occupational Health Program

INCOMING STUDENT IMMUNIZATION RECORD

(circle one)

MD (Houston Campus)

PA, O&P or Genetic Counseling

DNP

GSBS or BSHEq

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 months 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, DNP, genetic counseling, O&P students only.	

Please Return This Form Along With Records By Uploading To: https://hipaa.jotform.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

8/28/23