Galveston College Student Health Form

Name Date of Birth Student ID#

Tetanus, Diphtheria, Pertussis (Tdap) (This is an adult immunization, not the childhood series)	**MMR (Measles, Mumps & Rubella)** Born in or after 1957, two (2) doses are required. Born before 1957, one (1) dose is required or proof of Positive titer results.	**Varicella (Chicken Pox)** Two doses of Varicella Vaccine
Date ______________________	#1 Date ______________	#1 Date ______________
	#2 Date ______________	#2 Date ______________
	OR *Please attach lab report*	Date of illness ______________ (Must have positive titer to confirm)
	Measles Titer ___________ Results ____________	
Tetanus,Diphtheria (Td) (10 years after adult Tdap)	Mumps Titer ____________ Results ____________	**OR** *Report of a positive titer is required for all students*
Date ______________________	Rubella Titer ____________ Results ____________ **(Titers may be required from some clinical locations)**	Titer Date _________ Results __________

Tuberculin Test (PPD) Screening Must be within 12 months of the first day of class. Date ____________ Reading _________mm Induration

History of Positive PPD Positive PPD Date ________________ **INH Medication Taken** Yes No **Chest X-Ray** Date ____________ ***Attach report***

Hepatitis B	**OR**	**Hepatitis A & B Combination**
Completed series (3 doses) and positive titer (Hepatitis B surface antibody). (If titer antibody is negative, repeat series.)		
1st Series	2nd Series	
#1 Date ______________	#4 Date ______________	#1 Date ______________
#2 Date ______________	#5 Date ______________	#2 Date ______________
#3 Date ______________	#6 Date ______________	#3 Date ______________
Titer Date Results	Titer Date Results	Titer Date Results

Influenza Vaccine

School Year _____________ School Year _____________

Date ___________________ Date ___________________

I verify that the above information is an accurate report. (One of the below listed providers can list all immunizations and sign as official documentation. It does not have to be signed if turning in official paper documentation with this completed form.)

MD, DO, PA, NP, RN or LVN signature ________________________________ Printed Name _____________________________

Clinic Name and Address ____ Clinic Phone # ________________________