Addendum A
Medical Laboratory Science -Texas State
University Immunizations and Tests Form

Student's Name:_____TXSTATE ID#: A0_____Date of Birth: _____

Measles/Mumps/Rubella Vaccine - One of the following is required:	
A. Two doses of measles vaccine at least 28 days apart **OR**	Administration Date #1 _____ (mm/dd/yy) Administration Date #2 _____ (mm/dd/yy)
B. Serologic test positive for measles antibody	Date_____ (mm/dd/yy) Circle Results: Positive ☐ Negative ☐

Varicella (Chicken Pox) - One of the following is required:	
A. Two doses of Varicella vaccine administered 4-8 weeks apart **OR**	Administrative Date #1 _____ (mm/dd/yy) Administrative Date #2 _____ (mm/dd/yy)
B. Serologic test positive for Varicella antibody	Date_____ (mm/dd/yy) Circle Results: Positive ☐ Negative ☐

Tetanus (TDAP): <u>Tdap protects against Tetanus, Diphtheria, and Pertussis.</u> This vaccine is to be given every ten years. (Td is not acceptable)	Date _____ (mm/dd/yy)

Meningococcal Vaccine: Evidence of vaccination if student is 21 years or younger on the first day of the semester.	Date _____ (mm/dd/yy)

COVID-19 Vaccination Evidence of vaccination	***Vaccine***	***Manufacturer (Product Name) / Lot Number***	***Date***
	1st Dose		
	2nd Dose		
	Single Dose		
	Booster(s)		

Student's Name:_____Date of Birth: _____

Hepatitis B (HEP B) Series:

A. The 3-dose series of the vaccine administered over a period of at least 6 months (schedule of 0, 1, 6months).
Initial vaccine is followed by the second dose in 1 month and the third dose is 5 months after the second dose.
Note: Third vaccine must be at least 6 months from initial vaccine.

Dose #1 Administration Date #1 _____
(mm/dd/yy)

Dose #2 Administration Date #2: _____
(mm/dd/yy)

Dose #3 Administration Date #3 _____
(mm/dd/yy)

OR

B. Serologic test positive for Hepatitis B antibody.

Date _____ Circle Results: Positive ☐ Negative ☐
(mm/dd/yy)

OR

C. The 2-dose series (Heplisav-B) of the vaccine requires a minimum of 4 weeks between doses. The administration record must clearly identify the Heplisav-B series was given.

Heplisav- B Dose #1: _____
(mm/dd/yy)

Heplisav – B Dose #2:: _____
(mm/dd/yy)

Student's Name:_____Date of Birth: _____

Tuberculosis (TB) Testing: **2 Options** **A. One Step** Tuberculin Skin Test • Test with reading must be done prior to beginning classes in fall of 1st year **OR** **B. TB Blood test** *Use blood test if had prior positive blood test or if received BCG vaccine. Attention: Healthcare provider If a student tests positive for TB, include a synopsis of their treatment plan with this form. The following are suggested minimum requirements to be included in this plan: • Blood test (T-Spot or QuantiFERon) if the two step skin test was positive • Chest X-ray to be completed if positive blood test	**First Administration Date** _____ (mm/dd/yy) **Date Read**_____Circle Results: Positive ☐ Negative ☐ (mm/dd/yy) _____ Circle type of test: **T-Spot** **QuantiFERon** **Date**_____ Circle Results: Positive ☐ Negative ☐ (mm/dd/yy) **Treatment plan for Student** **Student Name**_____**DOB** _____

Physician or Approved Licensed Healthcare Provider Information:	
Printed Name ↓	
Address ↓	
Signature of Physician or Licensed Health Provider * ↓	Date ↓

*** Validates all information above**