UT SOUTHWESTERN MEDICAL CENTER
AT DALLAS
Student Health Services

Name: _____ **Date of Birth:** _____

Telephone Numbers: (Home):_____ **(Mobile):**_____ **(Work):**_____

Enrolled School (Medical, Graduate, or Allied Health):_____

Program if applicable (For example - Physician Assistant, Clinical Psychology, etc.):_____

Required Immunizations:

Immunization	**Date**	**Immune Titer** (Must attach a copy of titer)
(1). Tetanus/Diphtheria toxoid (Td)	**#1**____/____/____	
(2). Tetanus/Diphtheria/Pertussis (Tdap)	**#1**____/____/____	
(3). MMR	**#1**____/____/____, **#2** ____/____/____	
(4). Measles (Rubeola)	**#1**____/____/____, **#2** ____/____/____	____/____/____
(5). Mumps	**#1**____/____/____	____/____/____
(6). Rubella	**#1**____/____/____	____/____/____
(7). Hepatitis B	#1____/____/____, **#2** ____/____/____ **#3**____/____/____	____/____/____
(8). Varicella (Chicken Pox):	**#1**____/____/____, **#2** ____/____/____	____/____/____

History of Disease: ____/____/_____

(9). Tuberculin skin test (ppd) Date Placed: ___/____/____ Date Read: ____/____/____

Results: _____ millimeters of induration: _____

OR

History of a positive reading Date ____/____/____ millimeters of induration: _____

Chest x-ray results (Must include a copy of radiology report) Date ____/____/____ Results: _____

Verification of Information:

Signature of Health Care Provider: _____

Clinic or Office Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone #:_____ Fax# _____

5323 Harry Hines Blvd. / Dallas, Texas 75390-8861 / (214) 645-8690 Telefax (214) 645-8676