Immunization Record for Dental Hygiene at Texas Woman's University

Complete and mail or fax to:
Immunization Program
P.O. Box 425467
Denton, TX 76204-5467
Fax: (940) 898-3849
Phone: (940) 898-3825
(888) 898-8825

IMPORTANT: COMPLETION OF THIS PAGE IS NECESSARY TO COMPLY WITH TEXAS ADMINISTRATIVE CODE TITLE 25, P1, CH97, SUBCH B, RULE §97.61 AND THE POLICY OF TEXAS WOMAN'S UNIVERSITY.

Name: _____ TWU ID#: _____

Date of Birth: _____/_____/_____ Phone #: (_____) _____

Email Address: _____@_____ Alt. Phone #: (_____) _____

Current Address: _____
Address City/State Zip

PROOF OF THE FOLLOWING IMMUNIZATIONS IS REQUIRED PRIOR TO CLINICALS

MMR (Measles, Mumps, Rubella) **TWO injections since age one.**
ALL STUDENTS MUST PROVIDE PROOF OF RUBELLA

DOSE #1 Date _____

DOSE #2 Date _____

STUDENTS BORN ON OR AFTER JANUARY 1, 1957 MUST PROVIDE PROOF OF IMMUNITY TO MEASLES AND MUMPS.

ACCEPTABLE PROOF IS CONSIDERED TO BE:
1. RECORD OF IMMUNIZATION SIGNED BY A MEDICAL PROVIDER
2. DOCUMENTATION OF MEASLES, MUMPS AND/OR RUBELLA BY PHYSICIAN OR HEALTHCARE PROVIDER

MEASLES, MUMPS AND RUBELLA CAN ALSO BE PROVEN BY PROTECTIVE TITER – LAB REPORT MUST BE ATTACHED FOR COMPLIANCE

Tetanus/Diphtheria **Booster within 10 years** Date _____

Mantoux TB Skin Test (PPD) **Within Past One Year**

IF SKIN TEST IS POSITIVE, COMPLETION OF A CHEST CLEARANCE FORM IS REQUIRED ALONG WITH COPY OF CHEST X-RAY REPORT

Date Placed _____ Date Read _____ Results _____ mm of induration NEG / POS (circle one)

CHEST CLEARANCE FORM CAN BE PRINTED OFF THE WEB AT: http://www.twu.edu/o-sl/shs/TET.HTML

Hepatitis B Vaccine (series of 3)

Date #1 _____
Date #2 _____
Date #3 _____

Date of Titer _____ POS / NEG
(LAB REPORT MUST BE INCLUDED FOR COMPLIANCE)

Varicella Vaccine (must be at least 30 days apart)

Date #1 _____ Date #2 _____

OR

Varicella Titer Date _____
(LAB REPORT MUST BE INCLUDED FOR COMPLIANCE)

OR Varicella disease declaration (year must be included):
I verify that I had varicella disease (chickenpox) on or about (date) _____ and do not need varicella vaccine. **Student Initials**: _____

THIS FORM MUST BE SIGNED BY A HEALTHCARE PROVIDER OR COPIES ATTACHED MUST BE SIGNED BY A HEALTH PROVIDER

_____ _____ _____
Physician Name, Address, Phone Number (Office Stamp) Physician or Authorized Signature Date
Or Transcript from High School Record

Student must sign for record to be complete:
I certify that, to the best of my knowledge, the above information (including any attached copies) is true and correct.
I also give my consent for the release of my immunization records to faculty/staff at Texas Woman's University. I further consent to the release of my immunization records to any clinical facility that I request they be sent to for clinical rotations or employment.

_____ _____
Student Signature Date Signed

In accordance with Leg. House Bill 1922, an individual is entitled to request to be informed about the information collected about them; receive and review their information; and correct any incorrect information. Disclosure of your social security number is required in order to set up your immunization status at Texas Woman University. Your social security number will be used as a unique number to identify you. Any further disclosure of your social security number will be governed by the Public Information Act (Chp 552 of the Texas Government Code).

Revised October 2002