

R# \_\_\_\_\_ NAME \_\_\_\_\_ SON Program: \_\_\_\_\_  
Email: \_\_\_\_\_@ttuhsc.edu Phone number: \_\_\_\_\_ Start Date: \_\_\_\_\_

## TTUHSC SON Immunizations

**Copies of lab reports, immunizations and/or health records must be provided.**

1. **Varicella (Chicken Pox): Documentation of 2 Varicella vaccine doses**

Dose #1 date \_\_\_\_\_ Dose #2 date \_\_\_\_\_

**OR**

Documented Varicella immunity-titer **IgG** (blood test)

Date of Test: \_\_\_\_\_ (Attach Report)

**(TTUHSC does not accept history of disease)**

2. **Measles, Mumps, and Rubella (MMR):**

**Documentation of 2 MMR vaccine doses**

MMR #1-Date \_\_\_\_\_ MMR# 2-Date \_\_\_\_\_

**OR**

MMR **IgG** titer (blood): Date of test \_\_\_\_\_ (Attach Report)

3. **Tuberculosis: \* SON requires 2 negative TB skin tests within the last 12 months**

**\* If you have NOT had two negative TB tests within the last 12 months you must have a 2-step**

**Two – STEP = Two TB skin tests administered at least 7 days apart. Submit results below.**

**1<sup>st</sup> test** Date: \_\_\_\_\_ Result: \_\_\_\_\_ mm

**2<sup>nd</sup> test** Date: \_\_\_\_\_ Result: \_\_\_\_\_ mm

**If positive on TST**

Negative Chest X-Ray if (+) TST Date: \_\_\_\_\_ Result: \_\_\_\_\_

**Chest X-Ray must be no older than 1 year, if TB skin test is positive.**

(Attach Report)

**TTUHSC will also accept IGRA, T-SPOT or Quantiferon testing in place of a TB test, in the last 12 mths.**

Date: \_\_\_\_\_ Results: \_\_\_\_\_

**Visit 1, day 1:** Place the 1<sup>st</sup> TST and have the employee return in 7 days for the test to be read.

**Visit 2, day 7:** Place 2<sup>nd</sup> TST on all employees/volunteers whose 1<sup>st</sup> test is negative at 7 days.

**Visit 3, day 9 or 10:** Read the 2<sup>nd</sup> test at 48-72 hours.

**There are different ways of performing the 2-step TB, we accept any of them.**

[www.nationaltbcenter.edu](http://www.nationaltbcenter.edu)

4. **Hepatitis B series: Documentation of 3 Hepatitis B vaccine doses**

Dose#1 date \_\_\_\_\_ Dose #2 date \_\_\_\_\_ Dose #3 date \_\_\_\_\_

**OR**

Hepatitis B Surface Antibody **IgG** (blood test) Date of Test: \_\_\_\_\_ (Attach Report)

5. **Tetanus/diphtheria (Td): Tetanus Diphtheria booster (required within past 10 years)**

Td Date: \_\_\_\_\_ (Tdap will suffice)

6. **Tdap (Tetanus, Diphtheria, and Acellular Pertussis): Adult Dose**

Tdap date: \_\_\_\_\_

7. **Meningococcal Vaccine (MCV): Adults 22 and younger (vaccine within the last 5 years)**

MCV date: \_\_\_\_\_ circle exemption (age, online) DOB: \_\_\_\_\_

8. **Influenza Vaccine:** Influenza date: \_\_\_\_\_ (required during FLU season October-March)

**\*TTUHSC strongly recommends that you be vaccinated for COVID-19. If you have received the COVID-19 vaccine, please document below:**

9. **Covid- 19 Vaccine:** Documentation of Primary Monovalent Series Dose #1 and Dose #2 – OR – Bivalent Dose #1

Dose#1 Date \_\_\_\_\_ Dose#2 Date \_\_\_\_\_ Booster Date \_\_\_\_\_

**\*COVID-19 VACCINATION MAY BE MANDATORY AT SOME CLINICAL SITES. AT THIS TIME, TTUHSC DOES NOT REQUIRE YOU TO DISCLOSE WHETHER OR NOT YOU HAVE RECEIVED THE COVID-19 VACCINE. HOWEVER, FOR THOSE WHO DO NOT RECEIVE THE VACCINE OR OBTAIN AN APPROVED COVID-19 VACCINE WAIVER, IF APPLICABLE, YOUR ABILITY TO OBTAIN REQUIRED CLINICAL HOURS NECESSARY FOR PROGRAM COMPLETION MAY BE IMPACTED. FOR THOSE WHO WISH TO NOT DISCLOSE, IT WILL BE CONSIDERED THAT YOU HAVE NOT RECEIVED THE VACCINE FOR THE PURPOSES OF ADHERING TO CLINICAL SITE REQUIREMENTS.**

**This completed form and supporting documentation should be forwarded as soon as possible to:**

**Office of Institutional Health- TTUHSC Immunization coordinators**

**Traditional SON Students: [Karen.spees@ttuhsc.edu](mailto:Karen.spees@ttuhsc.edu) / FAX 806-743-2050**

**ABS/N/Graduate Online Students: [tinsteph@ttuhsc.edu](mailto:tinsteph@ttuhsc.edu) / FAX 806-743-2056**