Immunization and Health Survey

_____
Last Name (Please Print) **First** **Middle Initial** **Social Security Number**

_____
Date of Birth (Mo/Day/Yr) **Department** **Contact Phone #**

Provision of immunization documentation as noted below is one of the requirements for training at TTUHSC-EP (**Policy: EP 7.1, 7.1A**) and the affiliated hospital University Medical Center of El Paso.

- **Copies of lab reports, immunizations and/or health records must be provided.**
- **All results must be in English from a U.S. lab.**

1. Varicella: Must show proof of immunity, verified by blood titer.
   Date of Titer: _____ Result: _____ **(Attach copy of lab report)**
   In the event of a negative titer, two doses of Varicella vaccine at least 28 days apart is required.
2. Measles (Rubeola): Must show proof of immunity, verified by blood titer.
   Date of Titer: _____ Result: _____ **(Attach copy of lab report)**
   In the event of a negative titer, two doses of MMR at least 28 days apart is required.
3. Rubella: Must show proof of immunity, verified by blood titer.
   Date of Titer: _____ Result: _____ **(Attach copy of lab report)**
   In the event of a negative titer, two doses of MMR at least 28 days apart is required.
4. Mumps: Two doses of MMR vaccine **OR** Documented Mumps immunity-titer
   MMR #1-Date _____ MMR# 2-Date _____ **(Attach documentation)**
   -OR- Date of Titer: _____ Result: _____ **(Attach copy of lab report)**
   In the event of a negative titer, two doses of MMR at least 28 days apart is required.
5. Tuberculosis Testing (PPD): (Two-step testing is required)
   #1. Date placed:_____ Result _____ (mm) #2. Date placed: _____ Result: _____ (mm)
   If *positive TB skin test,* a Chest X-Ray (within three months) is required:
   CXR Date:_____ CXR Result: _____ **(Attach copy of X-ray report)**
   Students with positive TB skin test must show documentation of positive test and will be required to meet with TT-PLFSOM Infection control Nurse.
6. Hepatitis B: Hepatitis B series **AND** proof of immunity
   Dose #1_____ #2 _____ #3 _____ **(Attach documentation)**
   -AND- Hepatitis B Surface Ab: Date of Titer:_____ Result:_____ **(Attach copy of lab report)**
   In the event of a negative titer after the initial series, a second series and re-titer will be required,
7. Tetatus/Diphteria/Pertussis: (Tdap vaccine) Date: _____ **(Attach documentation)**
8. Influenza Vaccine: (when in season ~ generally Sept through April) Date: _____
9. List major Illnesses (if any): _____
10. Medications: _____
11. Allergies: _____
12. Emergency Contact:_____
    Name **Current Phone #**

*__e-mail address – in case we need to contact you:__ _____

You may NOT begin your training at TTUHSC/University Medical Center of El Paso until all above requirements are completed.