For Office Use Only: *SID* _____ *DOB* _____

Immunization Requirements & TB Screening Form for UTRGV 2019 Medical School Students

COMPLETION OF THIS FORM IS REQUIRED FOR REGISTRATION

STUDENT DEMOGRAPHIC INFORMATION

Date Form Completed:_____

Last Name _____ **First Name** _____ **MI**_____

Preferred Name:_____

Date of Birth _____-____-____ **SID#** (for secure medical record) _____

Male / Female / Transgender

UTRGV SOM STUDENT HEALTH REGISTRATION INFORMATION

Address (if known):_____ Zip_____

Local Phone # (____) _____ Cell Phone # (____)_____

E-mail address_____

EMERGENCY CONTACT

Last Name _____ First Name_____

Relationship to Student _____ Home Phone # (____)_____

Work Phone # (___)_____ Cell Phone # (____)_____

UTRGV Medical Student Immunization History

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COPIES OF ORIGINAL IMMUNIZATION RECORDS ARE REQUIRED
ALL ANTIBODY TITERS MUST SHOW QUANTITATIVE RESULTS

PAGES 2-4 MUST BE COMPLETED AND SIGNED BY A LICENSED HEALTHCARE PROVIDER

REQUIRED IMMUNIZATIONS AND TITERS

1.	Hepatitis B	Month/Day/Year	
	Dose #1	_____/_____/_____	
	Dose #2	_____/_____/_____	
	Dose #3	_____/_____/_____	
	If Series was completed in the last 3 months, Titer is Strongly Recommended to assess response		
	Hep B Titer Date	_____/_____/_____	Attach copy of lab results
2.	Measles, Mumps, Rubella	Month/Day/Year	
	Dose #1	_____/_____/_____	(Must be on or after 12 months of age)
	Dose #2	_____/_____/_____	(Must be 28 days or more after 1st dose)
	Titers are Required		
	Measles Titer Date	_____/_____/_____	Attach copy of lab results
	Mumps Titer Date	_____/_____/_____	Attach copy of lab results
	Rubella Titer Date	_____/_____/_____	Attach copy of lab results
3.	Varicella	Month/Day/Year	
	Dose #1	_____/_____/_____	(Must be on or after 12 months of age)
	Dose #2	_____/_____/_____	(Must be 28 days or more after 1st dose)
	OR		
	Varicella Titer Date	_____/_____/_____	Attach copy of lab results
4.	Tdap	Month/Day/Year	
	Adult Booster	_____/_____/_____	Booster date within last 10 years
5.	Polio Primary Series	Month/Day/Year	
	Date of Last Dose	_____/_____/_____	IPV or OPV
6.	Influenza:	_____/_____/_____	up to date with current season

Recommended Immunizations

1.	Hepatitis A	Month/Day/Year	
	Dose #1	_____/_____/_____	
	Dose #2	_____/_____/_____	
2	HPV		
	Dose #1	_____/_____/_____	
	Dose #2	_____/_____/_____	
	Dose #3	_____/_____/_____	
3.	Meningococcal	Type: A,C,Y,W and/or	Type B: (Trumenba or Bexsero)
	Dose #1	_____/_____/_____	
	Dose #2 (if applicable)	_____/_____/_____	
	Dose #3 (if applicable)	_____/_____/_____	

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Medical Student Tuberculosis History

REQUIRED TUBERCULOSIS SCREENING

***Select #1 or #2**

1. **Complete #1 if you have History of + IGRA test and completed Tb therapy:**

Month/Day/Year

Treatment Completed? _____/_____/_____

Symptoms Checked by PCP _____/_____/_____

●***If prior + IGRA, a current chest x-ray is required 5/1/2019 or later:***

Date of Chest X-ray: _____/_____/_____ **Normal or Abnormal**

2. **Quantiferon Gold/T-Spot IGRA:**

***Note that you must have an IGRA dated May 1, 2019 or later, regardless of history**

●**IGRA** _____/_____/_____ **Positive or Negative**

If newly documented positive, a chest x-ray is required May 1, 2019 or later: Date of Chest X-ray: _____/_____/_____ **Normal or Abnormal**

Has Treatment started?

Yes _____/_____/_____

No

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*SID*_____

DOB _____

Medical Student Health History

HEALTH HISTORY INFORMATION

Student's Name_____ **Student's Date of Birth** _____

Current Weight_____ **Current Height** _____

Current Diagnoses or Pertinent Past Medical History*:

1._____ 2._____

3._____ 4._____

*Students with blood-borne infections (HIV, Hepatitis C, and Hepatitis B) will be required to undergo further health screening at the Student Health Center upon arrival on campus. It is a university policy that these infections are self-disclosed by healthcare students and employees so that continuity of care for the student is arranged and patient safety is assured.

Allergies □ None

1._____ 2._____

Current Medications: □ None

1._____ 2._____

3._____ 4. _____

PSYCHIATRIC WELLNESS INFORMATION

Do you have any of the following diagnostic concerns?

1.	**Attention Deficit Hyperactivity Disorder**	**Yes**	**No**	**Current**	**Past**
2.	**Anxiety**	**Yes**	**No**	**Current**	**Past**
3.	**Bipolar disorder**	**Yes**	**No**	**Current**	**Past**
4.	**Depression**	**Yes**	**No**	**Current**	**Past**
5.	**Eating Disorder (Anorexia or Bulimia Nervosa)**	**Yes**	**No**	**Current**	**Past**
6.	**Treatment for alcohol or other drug treatment**	**Yes**	**No**	**Current**	**Past**
7.	**Other** _____	**Yes**	**No**	**Current**	**Past**

I certify the accuracy of the health information that I have provided UTRGV SOM. ***If I have recommended follow-up on the UTRGV campus, I have asked the student and his/her family to contact the appropriate resources prior to arrival to campus.***
Student Health Center 956-665-2511

Name _____ **(Printed or stamped name of healthcare provider)**

Address_____

Phone # ( ) _____

Signature _____ **Date** _____