Immunization Record

The **University of Dallas** recommends that all students follow the guidelines outlined by the American College Health Association (ACHA) for **"Institutional Prematriculation Immunizations"** PRIOR to registration.

For students who seek exemption for those vaccines REQUIRED by the state of Texas, an exemption form from the Texas Department of State Health Services MUST be submitted to the University of Dallas. The online form to request exemption is available at: https://corequest.dshs.texas.gov/

Last Name _________________________ **First Name**_________________________ **MI**_____ **DOB**___________

REQUIRED Vaccines		***Enter complete date (mo/day/yr)***			
Hepatitis B	Hep B or Hep A/B				*or date of titer:*
					or date of disease:
Meningococcal	MCV-4		within 5 years for those less than 22 years old.		
Tetanus-Diphtheria-Pertussis	DTaP/DTP					
Tetanus booster	Td/Tdap		within 10 years: circle Td or Tdap		

Recommended Vaccines		***Enter complete date (mo/day/yr)***				
Polio	OPV/IPV					
Measles/Mumps/Rubella	MMR					
Chickenpox	Varicella			*or date of titer:*		
				or date of disease:		
Hepatitis A	Hep A or Hep A/B					
Human Papilloma Virus	Gardasil					
Pneumococcal	PCV13 or PPSV23					
Influenza	TIV/LAIV					
Other						

Tuberculosis Screening (only if student at risk)

PPD ***or*** Date: __________ Result: ____ mm Negative ( ) Positive ( )

Quanti-FERON-TB Date: __________ Result: titer _________ Negative ( ) Positive ( )

If either test positive, CXR required: Date: __________ Results: Normal ( ) Abnormal ( )

Treatment: ____

To the best of my knowledge, the person named above has received the immunizations listed on this form.

HEALTH CARE PROVIDER SIGNATURE

Printed Name	Signature		Date
Address	City/State	Zip code	Phone Number