

Huston-Tillotson University Immunization Form

Name: _____ Date of Birth: _____ HT ID#: _____
(Last, First, Middle and/or Birth Name) (mm/dd/yyyy)

Preferred Name: _____ Phone: _____ Email: _____

Sex at Birth: Male Female Intersex/Ambiguous Pronouns: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Year & Semester Entering HT : _____ Fall Spring Previously enrolled at HT? No Yes - Year: _____

International Student? No Yes – Country of Origin: _____

Have your medical provider sign and date this form to verify all immunization dates entered **OR** you may attach a verified certificate of immunization with all required immunizations in lieu of a health care provider signature. **All records MUST be in English, or they will not be accepted.** The general deadline is June 15th for fall admissions and December 15th for spring admissions. **Per Texas law, YOU WILL BE WITHDRAWN FROM THE UNIVERSITY 30 days after classes begin if immunization requirements have not been met.**

SECTION A – Required for ALL Incoming Students – provide all dates in MM/DD/YYYY format

<p style="text-align: center;">MMR (Measles, Mumps, Rubella) <i>Two doses of Measles, Mumps, and Rubella (MMR)</i></p> <table border="1" style="width: 100%; border-collapse: collapse; margin-bottom: 10px;"> <tr> <td style="width: 50%; text-align: center;">(#1) mm/dd/yyyy</td> <td style="width: 50%; text-align: center;">(#2) mm/dd/yyyy</td> </tr> <tr> <td style="height: 20px;"></td> <td style="height: 20px;"></td> </tr> </table> <p style="text-align: center;">OR</p> <p>Serologic test date: _____</p> <p>Result: _____ <small>(Must attach a copy of results)</small></p>	(#1) mm/dd/yyyy	(#2) mm/dd/yyyy			<p style="text-align: center;">Diphtheria, Tetanus, and Pertussis <i>One dose Tetanus-Diphtheria (Td orTdap) within the last 10 years</i></p> <table border="1" style="width: 100%; border-collapse: collapse; margin-bottom: 10px;"> <tr> <td style="width: 50%; text-align: center;">(#1) mm/dd/yyyy</td> <td style="width: 50%; text-align: center;">(#2) mm/dd/yyyy</td> </tr> <tr> <td style="height: 20px;"></td> <td style="height: 20px;"></td> </tr> <tr> <td style="text-align: center;">(#3) mm/dd/yyyy</td> <td style="text-align: center;">(#4) mm/dd/yyyy</td> </tr> <tr> <td style="height: 20px;"></td> <td style="height: 20px;"></td> </tr> </table> <p>Tdap Booster Date: _____</p>	(#1) mm/dd/yyyy	(#2) mm/dd/yyyy			(#3) mm/dd/yyyy	(#4) mm/dd/yyyy			<p style="text-align: center;">Hepatitis B Vaccine <i>Three doses of Hepatitis B</i></p> <table border="1" style="width: 100%; border-collapse: collapse; margin-bottom: 10px;"> <tr> <td style="width: 50%; text-align: center;">(#1) mm/dd/yyyy</td> <td style="width: 50%; text-align: center;">(#2) mm/dd/yyyy</td> </tr> <tr> <td style="height: 20px;"></td> <td style="height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center;">(#3) mm/dd/yyyy</td> </tr> <tr> <td style="height: 20px;"></td> <td style="height: 20px;"></td> </tr> </table>	(#1) mm/dd/yyyy	(#2) mm/dd/yyyy			(#3) mm/dd/yyyy			
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(#1) mm/dd/yyyy	(#2) mm/dd/yyyy																					
(#3) mm/dd/yyyy																						
<p style="text-align: center;">Meningococcal Vaccine (MCV4) <i>Administered within the last 5 years until the age of 22*</i></p> <p><i>Vaccine Name</i></p> <table border="1" style="width: 100%; border-collapse: collapse; margin-bottom: 10px;"> <tr> <td style="width: 50%; text-align: center;">(#1) mm/dd/yyyy</td> <td style="width: 50%; text-align: center;">(#2) mm/dd/yyyy</td> </tr> <tr> <td style="height: 20px;"></td> <td style="height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center;">(#3) mm/dd/yyyy</td> </tr> <tr> <td style="height: 20px;"></td> <td style="height: 20px;"></td> </tr> </table>	(#1) mm/dd/yyyy	(#2) mm/dd/yyyy			(#3) mm/dd/yyyy				<p style="text-align: center;">COVID-19 Vaccine <i>Product Name/Manufacturer</i></p> <table border="1" style="width: 100%; border-collapse: collapse; margin-bottom: 10px;"> <tr> <td style="width: 50%; text-align: center;">(#1) mm/dd/yyyy</td> <td style="width: 50%; text-align: center;">(#2) mm/dd/yyyy</td> </tr> <tr> <td style="height: 20px;"></td> <td style="height: 20px;"></td> </tr> </table>	(#1) mm/dd/yyyy	(#2) mm/dd/yyyy			<p style="text-align: center;">(Continue on Reverse)</p> <p style="text-align: center;">Questions? Email Admissions@htu.edu</p>								
(#1) mm/dd/yyyy	(#2) mm/dd/yyyy																					
(#3) mm/dd/yyyy																						
(#1) mm/dd/yyyy	(#2) mm/dd/yyyy																					
<p>Comments:</p> <div style="border: 1px solid black; height: 100px; width: 100%;"></div>	<p style="text-align: center;">OR</p> <p>Age/date of disease: _____</p> <p style="text-align: center;">OR</p> <p>Serologic test date: _____</p> <p>Result: _____ <small>(Must attach a copy of results)</small></p>																					

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Student Name: _____ HT ID#: _____

SECTION B – Tuberculosis Screening – provide all dates in MM/DD/YYYY format

Tuberculosis Screening REQUIRED for students from countries with an increased incidence of Tuberculosis (TB)

Required to provide documentation of TB screening which was performed within one year prior to matriculation. Acceptable tests include either an IGRA Blood Test (usually acceptable from home country; report must contain student demographic information and results must be in English) or a TB skin test performed in the United States.

IGRA Blood Test (QuantiFERON or T-SPOT)
Must attach a copy of laboratory results

Date of Test mm/dd/yyyy	Result of Test
	<input type="checkbox"/> Positive <input type="checkbox"/> Negative

Tuberculin Skin Test (TST)

Must have been performed in the United States in the last year

Date Placed mm/dd/yyyy	Date Read mm/dd/yyyy	Result (mm induration)

Name and Credentials of Health Care Provider

Date

Name and Credentials of Health Care Provider

Phone

Office Address

City

State

Zip Code