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 **Per Texas law, YOU WILL BE WITHDRAWN FROM THE UNIVERSITY 30 days after classes begin if immunization requirements have not been met.**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

MMR (Measles, Mumps, Rubella)

Two doses of Measles, Mumps, and Rubella (MMR)

(#1) mm/dd/yyyy	(#2) mm/dd/yyyy

OR

Serologic test date: _____

Result: _____
(Must attach a copy of results)

Diphtheria, Tetanus, and Pertussis

One dose Tetanus-Diphtheria (Td orTdap) within the last 10 rs

(#1) mm/dd/yyyy	(#2) mm/dd/yyyy
(#3) mm/dd/yyyy	(#4) mm/dd/yyyy

Tdap Booster Date: _____

Hepatitis B Vaccine

Three doses of Hepatitis B

(#1) mm/dd/yyyy	(#2) mm/dd/yyyy
(#3) mm/dd/yyyy	

Proof of Hepatitis B immunity can be provided by one of the following: (1) a quantitative titer test showing anti-HBs levels of ≥10 mIU/mL, indicating immunity; (2) documented history of prior Hepatitis B infection; or (3) official records confirming completion of the Hepatitis B vaccination series.

Meningococcal Vaccine (MCV4)

*Administered within the last 5 years until the age of 22**

Vaccine Name

(#1) mm/dd/yyyy	(#2) mm/dd/yyyy
(#3) mm/dd/yyyy	

Meningococcal Conjugate Vaccine (MCV4): A booster dose is recommended if the previous dose was administered five or more years ago, particularly for individuals preparing to enter college or other group living environments

COVID-19 Vaccine

For those who are unvaccinated:
Administer 1 dose of the 2024–2025 Moderna or Pfizer-BioNTech vaccine, OR
Administer 2 doses of the 2024–2025 Novavax vaccine, spaced 3 to 8 weeks apart.

(#1) mm/dd/yyyy	(#2) mm/dd/yyyy

Date: _____

For those previously vaccinated with any COVID-19 vaccine before the 2024–2025 season:

If they received 1 or more doses of Moderna or Pfizer-BioNTech, give 1 dose of 2024–2025 Moderna, Novavax, or Pfizer-BioNTech, at least 8 weeks after the most recent dose.

If they previously received Novavax, administer 1 dose of the 2024–2025 formulation.

(Must attach a copy of results)

Meningococcal B Vaccine (Men B)

Vaccine Name

(#1) mm/dd/yyyy	(#2) mm/dd/yyyy

Individuals living in close residential settings, such as college dormitories, are at increased risk for Meningococcal B infection. To ensure adequate protection, it is recommended to receive one dose now, followed by a second dose six months later to complete the series.

If the individual has not previously received the MenB vaccine, the series should be started as soon as possible to provide protection during their time in group living environments.

Questions? Email
Admissions@htu.edu

(Continue on Reverse)

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Student Name: _____ HT ID#: _____

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

<u>Tuberculosis Screening</u> 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
	☐ Positive ☐ 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)

Chest X-Ray Evaluation (if applicable)

Date of Chest X-Ray: _____

Location/Facility: _____

Results: ☐ Normal ☐Abnormal ☐Pending

Reviewed by (Nurse/Clinician): _____

_____ Date _____

Name and Credentials of Health Care Provider

_____ _____

Name and Credentials of Health Care Provider Phone

_____ _____

Office Address City State Zip Code