

TB and Vaccination History for International Students

Please take this form and your immunization records to UHS when you arrive in Austin. Bring them to University Health Services, Allergy / Immunization Clinic, Student Services Building, 2nd floor. If you are outside of the U.S., please do not complete the TB screening portion. TB screening can be done at University Health Services.

International students cannot register for classes (even during new student orientation) until UHS has documentation that they have met the medical clearance requirements.

For questions regarding medical clearance requirements and medical bars, call our Immunization Compliance department at (512) 475-8301, or email imm@mail.uhs.utexas.edu. In your email, please provide your UT EID. Please be as detailed as possible about your question or circumstance.

STUDENT INFORMATION: Completed by Student

 First and Last Name of Student Date of birth

 UT Student EID Email

 Home Address, City, State, Country Telephone Number

TB SCREENING: Completed by the Health Care Provider

International students must receive TB test (PPD/Mantoux or IGRA) . A chest x-ray will NOT be accepted as a substitute for a test. However, a chest x-ray is required if either test is positive. The tuberculin requirement applies regardless of BCG vaccination. Screening can be done at UHS.
Must be performed in the U.S. on or after September 1, 2008.

TB Skin Test Results must be read in millimeters: Negative _____
 Positive mm of induration date of test (mm/dd/yyyy)

TB IGRA Blood Test Type: QFT-G TB IGRA Blood Test Results: Negative _____
 QFT-GIT Positive date of test (mm/dd/yyyy)
 Intermediate

If either test is positive, a chest x-ray must be performed in the U.S.A. on or after September 1, 2008.

Chest X-Ray Results: Normal _____
 Abnormal date of x-ray (mm/dd/yyyy)

History of INH treatment for tuberculosis infection:

Treatment completed as directed: Yes _____
 No date of completion (mm/dd/yyyy)

Licensed Health Care Provider: PLEASE PRINT CLEARLY OR STAMP

Signature (required) _____

Name _____

Address _____

Telephone (_____) _____ Date _____





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Required Vaccinations

MMR -- two doses of live MMR vaccine administered on or after the first birthday and at least 28 days apart. If disease history or titer, please indicate the date by the disease below. Disease history of Rubella is not sufficient to prove immunity.

Dates (mm/dd/yyyy)	Dose 1	Dose 2	Date of disease	Date of positive titer
Measles				
Mumps				
Rubella			not applicable	

Recommended Vaccinations

Dates (mm/dd/yyyy)	Dose 1	Dose 2	Dose 3
Varicella (chicken pox) <input type="checkbox"/> vaccine <input type="checkbox"/> disease history			
Tetanus-Diphtheria-Pertussis (Tdap)			
Tetanus-Diphtheria (Td)			
Human Papillomavirus, HPV			
Hepatitis A			
Hepatitis B			
Combination Hepatitis A and B			
Meningococcal <input type="checkbox"/> Menomune <input type="checkbox"/> Menactra			

Other Vaccinations

Dates (mm/dd/yyyy)	Dose 1	Dose 2	Dose 3
Pneumococcal Polysaccharide Vaccine			
Polio			
Typhoid			
Yellow Fever			
Other vaccination:			

Health Care Provider Information

Licensed Health Care Provider: PLEASE PRINT CLEARLY OR STAMP
 Signature (required) _____
 Name _____
 Address _____
 Telephone (_____) _____ Date _____

