IMMUNIZATION RECORD

The University of Texas M. D. Anderson Cancer Center

PLEASE PRINT OR TYPE

Directions: Return this immunization record prior to the effective date of your appointment to M. D. Anderson Cancer Center. Failure to submit required immunizations will delay your appointment. Documentation of immunizations must be in English or accompanied by a notarized translation.

Name: _____
Last (Family) Name First Name Middle Name

Date of Birth: _____ S.S.#: _____ Appointment Dates: _____

Current Mailing Address: _____ Home Phone: _____

DIPTHERIA-TETANUS: Proof of a booster shot within the past 10 years is required.
Date of Diptheria-Tetanus booster: _____

HEPATITIS B: If you have received the Hepatitis B vaccine, please indicate the following:
Date(s) of all vaccines received: _____ _____ _____
Post-Vaccine antibody testing & results: _____ _____ _____

MEASLES: Individuals must submit one of the following: (If born after 01/01/57)

(A) Signed physician's record documenting illness

(B) Signed physician's record documenting two (2) immunizations

(C) Laboratory report of immune serum antibody titer

If none of the above is available:
(A) Two (2) Measles immunizations must be given at least 30 days apart, unless contraindicated.
Date of first immunization: _____ Date of second immunization: _____

OR

(B) If one Measles immunization can be documented after 1969, Measles serum antibody titer can be drawn to ascertain immunity, then a second Measles immunization may be omitted.

Date of first immunization: _____ Date & result of Measles titer: _____

MUMPS: One of the following must be submitted: (If born after 01/01/57)

(A) Signed physician's record documenting illness.
(B) Signed physician's record documenting immunization.
(C) Laboratory report of immune serum antibody titer.

If none of the above is available, vaccine must be given unless contraindicated.
Date of Mumps vaccine: _____

RUBELLA: One of the following must be submitted:

(A) Signed physician's record documenting immunization

(B) Laboratory report of immune serum antibody titer

If neither of the above is available, vaccine must be given, unless contraindicated.
Date of Rubella vaccine: _____

TUBERCULOSIS: Skin Test-intermediate strength (5tu) within 12 months prior to registration is required.

Date of Skin Test: _____ (Old tuberculin NOT ACCEPTABLE)
Result at 48-72 hours: [ ] Negative [ ] Positive [ ] MM in duration
Result of Chest X-ray if positive: _____

VARICELLA: One of the following must be submitted:

(A) History documenting illness

(B) Signed physician's record documenting immunization

(c) Laboratory report of immune serum antibody titer

If none of the above is available, vaccine must be given unless contraindicated.

Date of Varicella vaccine: _____

Physician/Health Care Provider Name: (Print)_____

Address:_____
(Street) (City) (State) (Zip)

Physician/Health Care Provider's Signature:_____ Date: _____

Student/Trainee Signature: I certify that, to the best of my knowledge, the above information is correct.

Signature: _____ Date: _____

IN LIEU OF THIS DOCUMENT, INDIVIDUAL DOCUMENTS MAY BE SUBMITTED FOR EACH IMMUNIZATION REQUIRED.