

Immunization Record
The University of Texas M. D. Anderson Cancer Center

Instructions

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

Please Print or Type

Name: _____
Last First MI

Date of Birth: _____ **SS#:** _____ **Appointment Date:** _____
mm/dd/yy mm/dd/yy

Present Mailing Address: _____ **Home Phone:** _____
Number Street Apt. #

_____ City State

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

Hepatitis B: If you have received the Hepatitis B vaccine, please indicate the following:
 Date 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:

1. Two (2) measles immunizations must be given at least 30 days apart, unless contraindicated.
 Date of first immunization: _____ Date of second immunization: _____

OR

2. If one measles immunization can be documented after 1969 and 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: _____
 Date of second measles immunization, if necessary: _____

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 none 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 Code

Physician/Health Care Provider's Signature: _____

Student/Trainee Signature:

I certify that, to the best of my knowledge, the information above is correct.

Signature: _____ Date: _____

In lieu of this document, individual documents may be submitted for each immunization required.