

Date of TAMUCC Enrollment \_\_\_\_\_  
mo day yr

## TAMUCC Student Immunization Form

Texas A&M University - Corpus Christi policy require students to document immunizations in English for the following diseases. If you intend to enroll at the University, please complete and return this form to TAMUCC ESLI prior to the start of your first semester. Call 361-825-3435 if you have questions.

Name \_\_\_\_\_ University ID No. \_\_\_\_\_  
Last First Middle  
Permanent Address \_\_\_\_\_ Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Month Day Year

**Note: MMR vaccine is recommended to provide protection against measles, mumps and rubella**

**Rubeola:** (ten day measles): Must have the following:

Two immunizations required **at least thirty days apart** (after 1967 & not before first birthday)

1st immunization .....month/day/year received \_\_\_\_/\_\_\_\_/\_\_\_\_

2nd immunization.....month/day/year received \_\_\_\_/\_\_\_\_/\_\_\_\_

Or measles titer.....month/day/year tested \_\_\_\_/\_\_\_\_/\_\_\_\_ Results \_\_\_\_\_

Or physician-diagnosed measles disease.....month/day/year diagnosed \_\_\_\_/\_\_\_\_/\_\_\_\_

Vaccine not required if born before January 1, 1957 \_\_\_\_\_ (Please check only if applicable)

**Mumps:** Must have one of the following:

One immunization (not before first birthday).....month/day/year received \_\_\_\_/\_\_\_\_/\_\_\_\_

Or mumps titer..... month/day/year tested \_\_\_\_/\_\_\_\_/\_\_\_\_ Results \_\_\_\_\_

Or physician-diagnosed mumps disease.....month/day/year diagnosed \_\_\_\_/\_\_\_\_/\_\_\_\_

Vaccine not required if born before January 1, 1957 \_\_\_\_\_ (Please check only if applicable)

**Rubella:** (German/three day measles): Must have one of the following:

One immunization (not before first birthday).....month/day/year received \_\_\_\_/\_\_\_\_/\_\_\_\_

Or rubella titer .....month/day/year tested \_\_\_\_/\_\_\_\_/\_\_\_\_ Results \_\_\_\_\_

Physician-diagnosis rubella disease not acceptable.

Vaccine not required if born before January 1, 1957 \_\_\_\_\_ (Please check only if applicable)

**Tetanus/Diphtheria:** TD booster within last 10 years required (Tetanus alone not acceptable)

Immunization.....month/day/year \_\_\_\_/\_\_\_\_/\_\_\_\_

**Tuberculin Skin Test (TB)**(Mantoux only): **Administered at TAMUCC** for International Students

Date given \_\_\_\_/\_\_\_\_/\_\_\_\_ Date Read \_\_\_\_/\_\_\_\_/\_\_\_\_ Results \_\_\_\_\_ mm duration

Signature of physician or registered nurse reading test \_\_\_\_\_

Chest x-ray required if reading 10mm or greater: Date of chest x-ray \_\_\_\_\_ Results \_\_\_\_\_

**Meningococcal Conjugate (MCV4) (Meningitis)** **REQUIRED at least 10 days prior to moving on campus**

One immunization.....month/day/year received \_\_\_\_/\_\_\_\_/\_\_\_\_

**Physician's Signature:** Note: If not signed by a physician/registered nurse, you **must** provide proof of documentation

Name (print): \_\_\_\_\_ Signature: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

**Over - Medical Contraindication Statement**  
**Medical Contraindication Statement**

The individual identified on this form has been diagnosed with a medical condition which precludes receiving the following vaccines:

Vaccine	Medical Contraindication* of Vaccine	Probable Duration of Contraindication

It is understood that in the event the disease (except tetanus) for which this exemption requested occurs on campus, the individual will be excluded from all campus activities until Public Health Authorities declare the threat of disease has ended. This action will be taken to prevent the spread of disease to the individual who cannot medically receive the vaccine.

**Note:** Name, address, phone and signature of physician or clinic required to validate medical contraindication:

Name

---

Address

---



---

Phone

FAX

---

Signature

---

**\* Medical Contraindication to Vaccine must be in accordance with recommendations of Advisory Committee on Immunization Practices listed below:**

**General Contraindications**

1. Anaphylactic reaction to a vaccine contraindicates future doses of the vaccine
2. Anaphylactic reaction to a vaccine substance contraindicates the use of vaccines containing that substance

**Contraindications to MMR**

1. Anaphylactic reaction to eggs or neomycin\*
2. Pregnancy
3. Known altered immunodeficiency (hematologic and solid tumors, congenital immunodeficiency, or long term immunosuppressive therapy)
4. Measles vaccine should not be given for at least six weeks (preferably three months) after a person has received IG, whole blood, or other antibody containing products

**Contraindications to TB (Mantoux) skin test**

1. Students having recent viral infections or live virus vaccines (i.e. MMR). To obtain an accurate result when infection is strongly suspected, it is best to repeat testing several weeks after the illness, and 4-6 weeks after administration of the vaccine.
2. Past documented history of positive Mantoux. Chest x-ray required.

\* Vaccinate only with extreme caution. Consult protocols for vaccinating such persons (J Pediatrics 1983; 102:196-9 and JPediatrics 1988; 113:504-6)

## Consent For Treatment

Date \_\_\_\_\_

1. I, \_\_\_\_\_, (the) \_\_\_\_\_  
(Name of person giving consent) (relationship to patient)

of \_\_\_\_\_  
Name of Patient SS or Student ID # of Patient

hereby voluntarily consent to outpatient care encompassing routine diagnostic procedures, examinations, and medical treatment. This may include (but is not limited to) routine laboratory work, x-rays, administration of medications, inpatient and emergency care as needed.

2. I further consent to the performance of those diagnostic procedures, examinations, and the rendering of medical treatment by the office staff and their assistance as directed by the provider.

3. I authorize Student Medical Services to release medical information to third party insurance carriers for the purposes of filing insurance claims related to his/her medical care if applicable. I authorize Student Medical services to release any medical information to other physicians or medical providers as directed by the Student Medical Services Department. I authorize the release of medical information about his/her treatment to any other physician, provider or facility designated by me.

4. I understand that this consent form will remain in effect as long as the patient is a minor.

5 This form has been fully explained to me and I understand its contents.

Patient is a Minor \_\_\_\_\_ years of age. Date of birth \_\_\_\_\_

\_\_\_\_\_  
Signature of Legal Guardian

\_\_\_\_\_  
Witness