SUMMER HEALTH PROFESSIONS EDUCATION PROGRAM

FOR ACCEPTED STUDENTS

Immunization Information

To manage issues related to infection control, The University of Texas Health Science Center at Houston (UTHealth) **requires** the completion of the two forms (below) for visiting students who will be participating in a clinical setting. These forms **must** be submitted prior to participating in the program. If these forms are not completed and submitted, the student will be ineligible for program participation.

Please submit the following documents to Employee Health Clinical Services (EHCS) by secure fax to 713-486-0983.

- Certificate of Immunization
- VH3 Health History Form

Criminal Background Check

A Criminal Background Check - all students, faculty and staff are required to undergo a criminal background check prior to commencement of activities on campus. The same is true for matriculation to the vast majority of medical and dental schools around the country. SHPEP participation is contingent upon completion of a background check. The University of Texas Health Science Center (UTHealth) Human Resources Department will run the check at no cost to you. **Individuals who do not submit to the background check will be ineligible for program participation.**

Upon confirmation by the applicant of accepted status, the participant will receive an e-mail from a UTHealth Human Resources representative, who will initiate the criminal background check process.

Calculator Requirement for Statistics Course

Accepted scholars are **required** to bring a statistics-friendly calculator for the Statistics course: Texas Instruments 83+ or 84+. Specs/features and user guide may be accessed by clicking on the following links:

- TI-83 Plus
- TI-84 Plus Silver Edition
- Guide for TI-83, TI-83 Plus, or TI-84 Plus Graphing Calculator

UTHealth
The University of Texas
Health Science Center at Houston

UTHealth
Student Health Services

FAX To:
UT HEALTH
CLINICAL SERVICES
713-486-0983

CERTIFICATION OF IMMUNIZATION

Please return this form to UTHealth Student Health Services in person or at the fax number noted above. Do not send it to the Registrar's Office and DO NOT MAIL FORM.

You will be approved to register only after you satisfy all immunization requirements. Immunization requirements may vary by School. Please refer to the attached table to determine your specific requirements.

Please have your health care provider complete this certification of immunization. If you are a prospective or current student at UTHealth and need immunizations, you are welcome to use Student Health Services – no appointment is required (8:30 a.m. to 5:00 p.m., Monday through Friday). Please contact our clinic for current vaccination prices.

_____ _____ _____
Last Name, First Name Date of Birth Social Security #

Current Address:

_____
Street & Apt. #

_____
City, State Zip Code Country

Telephone (_____) _____ Alternate Telephone # (_____)_____

Please check which school(s) you will be attending:

( ) GSBS **(X) Dental** **( ) Biomedical Informatics**

(X) Medical **(X) Nursing** **( ) Public Health**

_____ _____

NAME **DOB**

REQUIRED IMMUNIZATIONS DATE (month/day/year)

1.**Tetanus/diphtheria** *or*
Tetanus diphtheria and Pertussis _____
(Within last 10 years)

2. **Measles (rubeola)** vaccine: #1 _____
(2 are required if born after January 1, 1957) ***or*** #2 _____
Positive rubeola titer (attach lab report) _____

3. **Mumps** vaccine ***or***
Positive mumps titer (attach lab report) _____

4. **Rubella** vaccine ***or*** _____
Positive rubella titer (attach lab report)

5. **Hepatitis B** vaccine series (3 injections) #1_____

#2_____

#3_____

OR Positive Hepatitis B surface antibody titer (attach lab report) _____

6. **Varicella** vaccine series (2 injections) #1_____

#2_____

OR Chicken pox disease (documented by health care provider) ***or***
Positive varicella titer (attach lab report) _____

7. Bacterial Meningitis (**Meningococcal)** vaccine**
(Within past 5 years) _____

8. Tuberculin skin test (PPD) required within the last 12 months, even if you received BCG vaccine as a child.

Date:_____ Result:_____ negative_____positive (measurement_____ mm if available)

If positive, did you take INH prophylaxis? _____ Yes ____ No

Chest x-ray findings if PPD is positive (attach x-ray report)

Date of chest x-ray: _____

Health Care Provider Printed Name and Signature License No.

Address City State Zip Code

Phone Number Fax Number

REQUIRED IMMUNIZATIONS	MINIMUM REQUIREMENT
Tetanus/Diphtheria or Tetanus Diphtheria and Pertussis	One dose within the past 10 years
Measles (Rubeola)	Two (2) doses of measles vaccine if born after January 1, 1957 administered on or after your first birthday and at least 30 days apart; **or** lab report of positive rubeola titer
Mumps	One dose of mumps vaccine administered on or after first birthday; **or** lab report of positive mumps titer
German Measles (Rubella)	One dose of rubella vaccine administered on or after first birthday; or immunity to rubella by presenting a lab report of positive rubella titer
PPD (TB) Skin Test	Within the past 12 months, even for those who have received BCG vaccine as a child. If PPD skin test is positive, a chest x-ray documenting no active tuberculosis must be submitted with immunization form
Hepatitis B Series	Three-dose series (second dose one month and third dose six months after first dose) or lab report of positive hepatitis surface antibody titer. Must be vaccinated to most current status possible prior to registering for classes.
****Meningococcal (Meningitis)**	Required of all incoming and transfer students 30 years old and younger. Students must have been immunized within the past 5 years **and** submit proof of immunization at least 10 days prior to the first day of class.
Varicella (Chickenpox) Series	Two-dose series (second dose one month after first dose) or a physician-validated history of the disease or lab report of positive varicella titer.

IMMUNIZATION REQUIREMENTS FOR EACH UTHealth SCHOOL

	Measles	Mumps	Rubella	Hepatitis B	Tetanus-Diphtheria or TdaP	PPD	Meningococcal **	Varicella
School of Biomedical Informatics	R	R	R	R	R	R	R	R
Dental School	R	R	R	R	R	R	R	R
Nursing School	R	R	R	R	R	R	R	R
Medical School	R	R	R	R	R	R	R	R
GSBS	R	R	R	R	R	R	R	R
School of Public Health	R	R	R	R	R	R	R	R

Key: R=Required

UTHealth
The University of Texas Health Science Center at Houston

VH-3 Form "Health History"

FAX To:
UT HEALTH
CLINICAL SERVICES
713-486-0983

University of Texas Employee Health Clinical Services (EHCS)

Health History Questionnaire Form

TYPE OR PRINT CLEARLY

Name:	Date of Birth: Gender: ☐ Male ☐ Female
Street Address:	City/State/ZIP/Country:
Your Contact Number(s):	Your email:
Your UTHealth Faculty Sponsor & Department/School: Dr. Robert Spears - SOD - SHPEP	Visitor Category: Visiting Student Trainee
CONFIDENTIALITY STATEMENT: This form requires that you provide personal health information that is protected by University policy and State and Federal law. Your rights to the confidentiality of your personal health information will be strictly maintained by EHCS. Your information will be used or disclosed in accordance with those policies and laws only to the minimal extent necessary for your treatment or business operations. All applicants must submit the completed form to their sponsored department, who will forward it to EHCS. Health Clearance will be sent, by email, to the sponsored department.	

Please indicate your classification:

( ) Pre-baccalaureate trainee (✓) Visiting Student trainee Estimated length of stay 1 Months 15 Days
( ) Professional trainee ( ) Visiting Scientist Estimated length of stay ____ Months ____ Days

Are you are visiting a laboratory, K-12 school, or be in a clinical setting? X Yes ❑ No ❑ Don't Know Yet
(If "Yes", proceed to 1.TB test below. If No, go to Page 2)
Your application will not be considered unless supporting documentation in English is included:

1. **Tuberculin (TB) skin test (PPD) required within the last 6 months, even if you received BCG vaccine.**
   1.1. Date of last TB skin test:_____ **(ATTACH DOCUMENTATION OR LABORATORY REPORT)**
      1.1.1. Result (mm)_____ Negative _____Positive (measurement_____ mm if available)
   1.2. Have you ever had a positive tuberculosis (TB) skin test? _____ Yes ____ No If yes, when? _____
      1.2.1. Chest x-ray findings if PPD is positive (attach x-ray report) Date of chest x-ray: _____
2. Hepatitis B Series. Three-dose series or laboratory report of positive hepatitis surface antibody titer **(ATTACH DOCUMENTATION OR LABORATORY REPORT)**
   2.1. #1 _____ #2 _____ #3 _____
3. Tetanus/Diphtheria or TDAP. One dose within the past 10 years. Date of last vaccination: _____
4. MMR/Measles booster. Two (2) doses of measles vaccine if born after January 1, 1957, administered on or after your first birthday and at least 30 days apart. Or laboratory report of positive rubeola, mumps, and rubella titers. #1_____ #2 _____
5. Varicella vaccine series (2 doses given at least 28 days apart) or Chicken pox disease (documented by health care provider) or positive varicella titer (attach lab report)
6. Seasonal influenza vaccination. Date N/A Attach evidence of vaccination. **Flue Shot is not necessary!**

Bloodborne Pathogen Exposure Questions:

1. While at The UTHealth, will you be exposed to human blood and bodily fluids? X Yes ❑ No ❑ Don't Know Yet
   1.1. If you are a **visitor** and have a risk of being exposed to bloodborne pathogens while at the University; do you want UTHealth to provide the vaccine series at your expense, or perhaps refer you to another source for the vaccination series? ❑ Yes ❑ No ❑ Don't Know Yet

If you answered "Don't Know Yet" to either question above (1 or 1.1), you need to ask your supervisor upon arrival at your assigned location. If the answer then becomes "Yes" to either question you must inform EHCS at 713-500-3248.

VH-3 Form "Health History"

If you will be exposed to human blood and bodily fluid and choose NOT to accept the vaccine, please read and sign the statement below:

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B (HBV) infection. I have been given the opportunity to be vaccinated (at my own expense) with Hepatitis B vaccine at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B infection, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccine series at my own expense.

_____ _____

Hepatitis B - Declination Signature **Date**

Past History and Review of Systems:

Please check if you have ever had any of the following:

- ☐ Skin Problems
- ☐ Communicable Diseases
- ☐ Persistent or unusual cough
- ☐ Color blindness/vision problems
- ☐ Loss of consciousness/seizures/ convulsions
- ☐ Unsteadiness in balance/dizzy spells
- ☐ Diabetes/Sugar disorders
- ☐ Neck/back/knee problems
- ☐ Difficulty with hearing
- ☐ Hepatitis
- ☐ Alcohol/drug abuse
- ☐ Psychiatric/emotional problems/depression/anxiety

For any items checked above, are you or were you under the care of a physician? ☐ Yes ☐ No

Comments:

Signature **(Visitor)** **Date**

_____ _____

Office Use Only

Seasonal Influenza: _____ MMR Booster: _____ Td/TDap Booster _____

Hepatitis B Vaccine: #1_____ #2_____ #3_____

TB Skin test given: Date _____ TB skin test result ____mm Date of reading_____

Sent for CXR: Date_____ Result: _____

☐ Occupational Health Enrollment Form (Working with Animals)

☐ Respiratory Clearance form for EHS ☐ Schedule Spirogram ☐ Fax Respiratory Clearance form to 713.500.5841

☐ Not cleared