# Immunizations and Tests
# Required by State Law/Clinical Facilities

**Name:** _____ **Date of Birth:** _____

**Program:** _____ **FPC ID#:** _____

**Measles (Rubeola):** Those born on or after January 1, 1957, must show proof of either:

| | |
|---|---|
| **A.** **Two** doses of measles vaccine on or after their first birthday and at least 30 days apart **OR** ***See note.** | Date #1 (mm/dd/yy) Date #2 (mm/dd/yy) |
| **B.** Record of physician-diagnosed measles **OR** ****See note.** | Date _____ (mm/dd/yy) |
| **C.** Serologic test positive for measles antibody ****See note.** | Date (mm/dd/yy) Result |

**Mumps:** Those born on or after January 1, 1957, must show proof of either:

| | |
|---|---|
| **A.** One dose of mumps vaccine on or after their first birthday **OR** | Date _____ (mm/dd/yy) |
| **B.** Record of physician-diagnosed mumps **OR** ****See note.** | Date _____ (mm/dd/yy) |
| **C.** Serologic test positive for mumps antibody ****See note.** | Date _____ Result _____ (mm/dd/yy) |

**Rubella:** Those born on or after January 1, 1957, must show proof of either:

| | |
|---|---|
| **A.** One dose of Rubella vaccine on or after their first birthday **OR** | Date _____ (mm/dd/yy) |
| **B.** Record of physician-diagnosed Rubella **OR** ****See note.** | Date _____ (mm/dd/yy) |

| | |
|---|---|
| **C.** Serologic test positive for Rubella antibody<br>****See note.** | Date _____ Result<br>_____<br>(mm/dd/yy) |

***Combined MMR Vaccine is vaccine of choice if recipients are likely to be susceptible.**
****Must be the date of diagnosis or test collection; not when primary care provider signed immunization form.**
**+Vaccines administered after September 1, 1991 shall include the MM/DD/YY each vaccine was given.**

| **Hepatitis B** must show proof of: | |
|---|---|
| **A.** Three doses of vaccine administered over a period of 4 to 6 months **OR** **There is a 4 month accelerated series approved by the CDC and TDHS. Administer vaccine at 1st month, 2nd month, & 4th month.** | Date #1<br>_____<br>_____<br>(mm/dd/yy)<br>Date #2<br>_____<br>_____<br>(mm/dd/yy)<br>Date #3<br>_____<br>_____<br>(mm/dd/yy) |
| **B.** Serologic test positive for Hepatitis B antibody<br>****See note.** | Date _____ Result<br>_____<br>(mm/dd/yy) |

| **Varicella** must show proof of: | |
|---|---|
| **A.** **Two** doses of Varicella vaccine administered 4-8 weeks apart **OR** | Date #1 _____ Date #2<br>_____<br>(mm/dd/yy) (mm/dd/yy) |
| **B.** Serologic test positive for Varicella antibody **OR**<br>****See note.** | Date _____ Results<br>_____<br>(mm/dd/yy) |
| **C.** Physician documented history of diagnosis of Varicella<br>****See note.** | Date Disease Occurred<br>_____<br>_____<br>(mm/dd/yy) |

| | |
|---|---|
| **Diphtheria, Tetanus (TDAP):**<br>One dose within past 10 years<br>**Meningococcal** | Date _____<br>(mm/dd/yy)<br>Date_____<br>(mm/dd/yy) |

| | |
|---|---|
| **Tuberculin Test (PPD):** | Date Administered _____ Date Read:_____ |

| | |
|---|---|
| Must be performed annually<br><br>*Or copy of chest x-ray report if reactive PPD | Results: _____ Test Read By: _____ |

| **Primary Care Provider Information:** | |
|---|---|
| Printed Name | |
| Address | |
| Signature of Primary Care Provider | Date |

**Original form must be returned to the Vocational Nursing Department!!!**
Reviewed 1/2026