

UST RESIDENTIAL Immunization Form

Student Name: First _____ Last _____ MI _____

Student ID #: _____ Date of Birth: ___/___/___ Date of UST Entry: ___/___/___

You must have a health care provider complete and sign this form OR you may submit a copy of your official immunization records.



UNIVERSITY OF
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Please complete and mail to:
University of St. Thomas
Office of Health Promotion and Wellness
3800 Montrose Boulevard, Box #80
Houston, TX 77006



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Or scan and email to immunizations@stthom.edu
or Fax to 713-525-3514. Forms can also be uploaded to your MYSTTHOM

REQUIRED IMMUNIZATION FOR ALL NEW STUDENTS under age 22.

This information does not apply to students 22 years of age or older and students enrolled only in online or other distance courses.

MENINGOCOCCAL MENINGITIS

Must have had the meningitis immunization (MPSV4 or MCV4) **NOT Meningitis B**
After 16th birthday & within the last 5 years prior to enrollment

Month/Day/Year

___/___/___

All immunizations listed below are REQUIRED FOR ALL RESIDENTIAL STUDENTS

M.M.R. (Measles, Mumps, Rubella) (Two doses required)

Month/Day/Year

A. Dose 1 given on or after 1st birthday, AND on or after January 1, 1957

___/___/___

B. Dose 2 given 15 months after birth or later, and at least 28 days after first dose

___/___/___

TETANUS DIPHTHERIA (Td booster in the last **TEN** years meets requirement)

Tetanus Diphtheria (Td) or tdap booster within the last **ten** years.

___/___/___

TUBERCULOSIS TEST (**Required for all on-campus residents.** Note: international students must have been tested within the last 12 months prior to moving into campus housing. Domestic students can be from any year).

Result: Neg ___ Pos ___ mm induration (horizontal diameter) _____

___/___/___

If PPD is positive, chest X-ray required: X-ray result: Normal ___ Abnormal ___

___/___/___

If PPD is positive have you had INH prophylaxis? No ___ Yes ___ Date completed _____

Note: If you are living on campus there is a 10 day waiting period from the time the meningitis vaccination is received to be allowed to move into the residence halls.

Signature of Health Care Provider: _____

Date: _____

Printed Name of Health Care Provider / Clinic: _____

Health Care Provider/ Clinic Phone #: _____