

University: **Texas A&M University**

Student:

DOB:

## ✓ HOW TO COMPLETE THESE FORM(S):

- ☐ A licensed healthcare professional **MUST** complete and sign **THESE** forms. **ALL green sections are required.**
- ☐ **PRINT CLEARLY WITH DARK BLACK INK.** A computer will be reading your forms. Fill in circles completely.
- ☐ **NO** other forms of documentation will be accepted. (Blue Cards, Yellow Cards, State Immunization Records, etc. are NOT accepted)
- ☐ Do not fold, cut, or mark on the border lines of these forms.
- ☐ Include the Border Lines in your scanned images.
- ☐ Review your forms for completeness and accuracy. Double check **ALL** signatures. **MM/DD/YY date formats.**
- ☐ Consult your Healthcare Professional before receiving any of the following immunizations.

**Your records are due by: Orientation or 8/1/2018 ...whichever comes first!**

REQUIRED	RECOMMENDED	OPTIONAL
Required by regulation and /or policy to attend this university.	Recommended for your general well being but NOT required.	Optional information
<b>Documents:</b> Immunization Certificate <b>Immunization Dates:</b> Meningococcal (1 dose within 5 yrs)	<b>Immunization Dates:</b> Varicella Hepatitis A Hepatitis B HPV Influenza Tb Test Results MMR Meningococcal B	<b>Immunization Dates:</b> Polio Pneumococcal JE - Japanese Encephalitis Typhoid Yellow Fever Rabies

## ✓ UPLOADING YOUR FORMS:

- ☐ Review your forms for completeness and accuracy. **Double check ALL signatures.**
- ☐ Scan or photograph your documents as JPGs for upload. Be sure to include the border lines and fill the picture frame.
- ☐ Upload your completed forms to your account at medproctor.com.
- ☐ You may upload your additional documentation for storage and later retrieval. (blue cards, state records, etc.)
- ☐ Check your University Email account regularly for messages from MedProctor regarding incomplete information.

*You will be notified via email once your information is successfully verified.*

### BE AWARE:

- \* Incomplete/Illegible writing and poor images will be rejected.
- \* Completion of these forms by your due date will help expedite your registration process.

**Do not upload this page.**

# IMMUNIZATION CERTIFICATE



PRINT CLEARLY WITH DARK BLACK INK.

This form will be read by a computer.

Upload to medproctor.com

University: **Texas A&M University**

Student: \_\_\_\_\_

DOB: \_\_\_\_\_

Green = Required

Blue = Recommended

Black = Optional

MMR Measles, Mumps, Rubella Recommended	HEPATITIS B Recommended	VARICELLA - Chicken Pox Recommended	INFLUENZA Recommended
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<b>MENINGOCOCCAL Required</b>	3rd <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<b>HEPATITIS A Recommended</b>	One <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
1st <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<b>HPV - Human Papillomavirus Recommended</b>	1st <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<b>Yellow Fever Optional</b>
2nd <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	1st <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	2nd <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	One <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<b>MENINGOCOCCAL B Recommended</b>	2nd <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<b>POLIO - Inactivated Optional</b>	<b>RABIES - Pre-Exposure Optional</b>
1st <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	3rd <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	1st <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	1st <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<b>PNEUMOCOCCAL Optional</b>		2nd <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	2nd <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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PPSV23 <input type="radio"/> PCV13 <input type="radio"/>		4th <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

## REQUIRED - Immunization History Signature (Please clearly complete ALL and place office stamp at bottom of page.)

LICENSED CARE PROFESSIONAL SIGNATURE	PRINT LICENSED HEALTH CARE PROFESSIONAL FIRST AND LAST NAME	SIGNATURE DATE
NON-PARENTAL		
NPI NUMBER <small>not required for U.S. service members or international students</small>	NPI NAME OF LICENSED HEALTH CARE PROFESSIONAL	OFFICE PHONE NUMBER

## RECOMMENDED - Tuberculosis Test Results

<b>Tb Skin PPD</b> Placed: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Read: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> actual induration in MM only <input type="text"/> <input type="text"/>	mm and range REQUIRED (fill bubble) <input type="radio"/> 0 mm <input type="radio"/> 0 to < 5 mm <input type="radio"/> 5 to < 10 mm <input type="radio"/> 10 to < 15 mm <input type="radio"/> 15 mm or larger	<b>OR</b>	<b>Tb Blood</b> T-Spot QuantIFERON Test <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>Results</b> <input type="radio"/> Positive <input type="radio"/> Negative
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## Tuberculosis Test Results Signature (Please clearly complete ALL and place office stamp at bottom of page.)

LICENSED CARE PROFESSIONAL SIGNATURE	PRINT LICENSED HEALTH CARE PROFESSIONAL FIRST AND LAST NAME	SIGNATURE DATE
NON-PARENTAL		
NPI NUMBER <small>not required for U.S. service members or international students</small>	NPI NAME OF LICENSED HEALTH CARE PROFESSIONAL	OFFICE PHONE NUMBER

OFFICE STAMP

