RADIOLOGIC TECHNOLOGY PROGRAM

Health Record/Immunizations

Student Name:_____ D.O.B._____

- **Meningitis(MV)** Texas Legislature Senate Bill 1107 if 30yrs old or younger _____

  It is also required that the student receive the Hepatitis B immunizations.

- **Hepatitis B injections required** **Hepatitis B**

Series: _____, _____, _____Titer_____

- **Tuberculosis Test:** ***(Dated test results must be submitted with this form)***

or Tine	Positive ____	Negative ____
or Tuberculin	Positive ____	Negative ____
or Chest x-ray	Positive ____	Negative ____

- **Measles, Mumps, Rubeola**

Date: _____, _____, _____

or Titer_____

- **Varicella** **Varicella**

Date _____ or Titers _____

- Tetanus

Records must reflect a Diphtheria Tetanus Toxoid Booster within the last ten years.

Date of Booster-_____

***Influenza/Seasonal Flu immunization (required annually, during flu season, Sept-March or April.

I authorize release either verbally or in writing, the information contained in the health records to Parker University and its Clinical Affiliates.

_____ _____

Student Signature Date