



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.

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

**✓ 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

<b>MMR</b> Measles, Mumps, Rubella <b>Recommended</b> 1st _____ 2nd _____ <b>MENINGOCOCCAL</b> <b>Required</b> 1st _____ 2nd _____ <b>MENINGOCOCCAL B</b> <b>Recommended</b> 1st _____ 2nd _____ <b>PNEUMOCOCCAL</b> <b>Optional</b> One _____ PPSV23 <input type="radio"/> PCV13 <input type="radio"/>	<b>HEPATITIS B</b> <b>Recommended</b> 1st _____ 2nd _____ 3rd _____ <b>HPV</b> - Human Papillomavirus <b>Recommended</b> 1st _____ 2nd _____ 3rd _____	<b>VARICELLA</b> - Chicken Pox <b>Recommended</b> 1st _____ 2nd _____ <b>HEPATITIS A</b> <b>Recommended</b> 1st _____ 2nd _____ <b>POLIO</b> - Inactivated <b>Optional</b> 1st _____ 2nd _____ 3rd _____ 4th _____	<b>INFLUENZA</b> <b>Recommended</b> 1st _____ <b>Typhoid</b> - Inactivated <b>Optional</b> One _____ <b>Yellow Fever</b> <b>Optional</b> One _____ <b>RABIES</b> - Pre-Exposure <b>Optional</b> 1st _____ 2nd _____ 3rd _____
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**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: _____ Read: _____ actual induration in MM only _____ mm and range <b>REQUIRED</b> (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 _____ Results <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

