

What is the Immunization Verification Form? If an applicant is selected this allows our Employee Health Office to process tentatively accepted students more efficiently.

Where can I go to get this form filled out? It is the applicant's responsibility to contact their healthcare provider or a healthcare provider of their choice. Explain to them that you are applying to a radiography program and are required to have this form completed by a healthcare provider. The applicant must gather all their shot records and take to the healthcare provider of their choice. The healthcare provider will copy over the information you provide them.

To be completed and signed by a physician or other licensed Health Care Provider. Examples are a Registered Nurse, Nurse Practitioner or Physician that is licensed by the state and has a professional association to a health care facility.

What if I cannot get this form completed by the deadline? This form is a required document for the application process. If you are having difficulty getting this form completed, please email in a timely manner Lana Scherer @ schererl1@covhs.org. If you are unable to get this form completed by the deadline, please check our website to apply for the next application cycle.

Where can I get a copy of my immunization records? Here are some recommendations as to where to look for your immunization/vaccine records.

Check with your medical provider/clinic and schools that you have attended.

Can I just turn in my shot record? No, this form is a required form for the application process.

What if I do not have any documentation of my shot records? If you have no documentation at all, you can have the serologic test/s (lab work) for those immunizations that you do not have documentation for or you may get the immunizations again if needed.

Will additional documentation of immunizations be required if selected? No additional requirements will be required once the applicant is accepted.

Will I need to report Covid-19 vaccinations? Yes, CSOR requires that all CSOR students be fully vaccinated or have an approved exemption prior to starting classes. Proof of vaccinations or exemptions are required.


If you have questions, please email Lana Scherer at: schererl1@covhs.org.

Applicant Name: _____

DOB: _____

Last 4 of SS#: _____

To be completed by a Physician or Other Health Care Provider. Please do not sign the compliance form unless the named person has proper vaccines or immune test. Note: All vaccines administered after September 1, 1991, shall include the MM/DD/YYYY that each vaccine was given.

Immunization	For each of the date please list in the following format of mm/dd/yyyy:	Option #2 	If you do not have documentation of the required Immunizations:
Measles (Rubeola)*: Two doses of measles- containing vaccine on or after January 1, 1968.	Date #1 _____ Date #2 _____ (mm/dd/yyyy) At least 30 days apart	OR Serologic test positive for Measles antibody	Date _____ (mm/dd/yyyy) Results _____
Mumps: One dose of mumps vaccine on or after January 1, 1957.	Date #1 _____ Date #2 _____ (mm/dd/yyyy)	OR Serologic test positive for Mumps antibody	Date _____ (mm/dd/yyyy) Results _____
Rubella: One dose of rubella vaccine on or after the first birthday.	Date #1 _____ Combined MMR Vaccine is vaccine of choice if recipients are likely to be susceptible. ** Must include date of test collection. **	OR Serologic test positive for Rubella antibody	Date _____ (mm/dd/yyyy) Results _____
Varicella: Two doses of varicella vaccine. History of Disease is not accepted. Must have Vaccine or Titer.	Date #1 _____ Date #2 _____ (mm/dd/yyyy) At least 30 days apart	OR Serologic test positive for Varicella antibody	Date _____ (mm/dd/yyyy) Results _____

IMPORTANT NOTICE TO APPLICANTS: Please be aware that all of our students are required to have completed the HEP B series before the start of school. If you have not yet begun to receive this series, or if you will not have it completed before classes begin, you will not be eligible for admission. **THIS IS A NON-NEGOTIABLE REQUIREMENT.**

Hepatitis B: (3 doses) Date #1 _____ Date #2 _____ Date #3 _____ (mm/dd/yyyy)	OR	Serology/Titer (Lab work results) Date _____ (mm/dd/yyyy) Results _____ Must include date of test collection and results; it is highly recommended that applicants complete lab work.
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Note: An accelerated dosing schedule with Twinrix vaccine (Hepatitis H and Hepatitis B recombinant) may be an option to meet Texas DSHS requirements for Hepatitis B immunization.

Tdap: One dose of Tdap within the last 10 years.		Date _____ (mm/dd/yyyy)	
Bacterial Meningitis: For those that are 22 years old or younger.	MCV-4 Date _____ (mm/dd/yyyy)	OR	MPSV-4 Date _____ (mm/dd/yyyy)
To be completed and signed by a physician or other licensed Health Care Provider. Examples are a Registered Nurse, Nurse Practitioner or Physician that is licensed by the state and has a professional association to a health care facility. Signature: _____ Signature validates all information on this form. Date: _____		Name of Dr./Office: _____ Address: _____ City: _____ State: _____ Phone: _____	