A Member of The Texas State University System

ATHLETIC TRAINING PROGRAM
801 Bowers Boulevard, Box 2176
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PHYSICIAN OR OTHER HEALTH CARE PROVIDER VERIFICATION: To be completed by the Health Care Provider:

Student Name:		DOB:
Measles, Mumps, Rubella Two doses or positive IgG titers for Measles/Mumps/Rubella		
1st Immunization: _____ 2nd Immunization: _____ OR IgG Titer (date): _____ IgG Titer (results): _____		
Hepatitis B* Three		Tdap One dose of Tetanus/Diphtheria/Pertussis MUST HAVE HAD TDAP AS AN ADULT (after age 18)
1st		