IMMUNIZATION RECORD FORM

FOR OFFICE USE ONLY:	
REC'D ____	RX____
RC ____	____ MMR
IMS ____	____ MENI
PNC ____	
Notified	____ TBRA
________	____ TST
________	____ TBFU

Return this form by mail or fax to:
Thomson Student Health Center Allergy/Immunization Clinic
1409 Devine St.   Columbia, SC   29208
For questions, email immunize@sc.edu or call 803-777-9511.
Fax: 803-777-3955

Enter all immunization dates online at **My Health Space** at www.sc.edu/myhealthspace before submitting this form.

PLEASE PRINT: To be completed by student.

Name ____
Last   First   Middle

Address ____
Street/P.O. Box

____
City   State   ZIP   Country

Home Phone (____) ______________   Cell Phone (____) ____________________Email__________________________

First term of enrollment (circle)   Fall   Spring   Maymester   Summer I   Summer II   Year 20 ______

Date of birth: ______ / ______ / __________   Age at the time you will enter the University: ___________
mm   dd   yyyy

Social Security # or ID number for internationals (**REQUIRED**): __________ - ________ - __________

□ Freshman   □ Transfer   □ International student   □ Distance education   □ Other: ____________________

Student signature ____

SECTION A: REQUIRED IMMUNIZATIONS: Must be completed/signed by healthcare provider.

1. **MMR (Measles, Mumps, Rubella): Two doses required for students born in 1957 or later.**
   - □ Dose 1 - Given at age 12 months or later   Date of administration: ____/____/____
   - □ Dose 2 - Given at least 28 days after the first dose   Date of administration: ____/____/____
   - □ Exemption: I was born before 1957 and am exempt from this requirement.

   OR proof of positive MMR titer results. (**Attach lab reports.**)

2. **Meningococcal vaccine: Required for all incoming students under 21 years of age.**

Proof of receipt of a conjugate meningococcal vaccine (e.g. Menactra or Menveo) or a signed waiver declining the vaccine is required for all incoming students under 21 years of age. If it has been between 2 and 5 years since you received the Menomune vaccine, it is recommended you get the Menactra or Menveo vaccine. If it has been more than 5 years since you received any meningitis vaccine, you are required to get the Menactra or Menveo vaccine.

- □ Menactra   Date of administration   _____/_____/_____ (mm dd yyyy)
- □ Menveo   Date of administration   _____/_____/_____ (mm dd yyyy)
- □ Menomune   Date of administration   _____/_____/_____ (mm dd yyyy)

I have read the CDC guideline page inserted in this document and understand the risks associated with meningococcal disease.

□ Declined vaccination (signature required) ______________________________________ Date: __________

(SECTION A CONTINUED)

Name: ____

Last First Middle

Date of birth: ______ / ______ / __________

3. Tuberculosis (TB) screening questionnaire. (See page 3.)

Have you ever had a positive TB skin test? □ Yes □ No

Have you ever had close contact with anyone who was sick with TB? □ Yes □ No

Were you born in one of the countries listed below and arrived in the U.S. within the past 5 years? □ Yes □ No

If yes, please CIRCLE the country.

Have you traveled to a country listed below and stayed more than one month? □ Yes □ No

If yes, please CIRCLE the country.

If the answer is YES to any of the above screening questions, you must complete page 3.
The University of South Carolina requires that students complete a *tuberculosis risk assessment* by a physician or healthcare facility if risk is noted on TB screening questionnaire.

Afghanistan
Algeria
Angola
Argentina
Armenia
Azerbaijan
Bahrain
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cambodia
Cameroon
Cape Verde
Central African Republic
Chad
China
Colombia
Comoros
Congo
Côte d'Ivoire
Croatia
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
Fiji
Gabon
Gambia
Georgia
Ghana
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Japan
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libyan Arab Jamahiriya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Micronesia (Federated States of)
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nepal
Nicaragua
Niger
Nigeria
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Saint Vincent and the Grenadines
Sao Tome and Principe
Senegal
Seychelles
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
Sri Lanka
Sudan
Suriname
Swaziland
Syrian Arab Republic
Tajikistan
Thailand
The former Yugoslav Republic of Macedonia
Timor-Leste
Togo
Tunisia
Turkey
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

Source: World Health Organization Global Tuberculosis control, WHO Report 2010, Countries with Tuberculosis incidence rates >20 cases per 100,000 population.

TUBERCULOSIS (TB) RISK ASSESSMENT

(Required if risk noted on TB screening questionnaire)

PATIENT SECTION

Recent close contact with someone with infectious TB disease	□ Yes □ No
Foreign-born from (or travel to/in) a high-prevalence area (See list of countries on the previous page.)	□ Yes □ No
Abnormal prior chest x-ray suggesting inactive or past TB disease	□ Yes □ No
HIV/AIDS	□ Yes □ No
Organ transplant recipient	□ Yes □ No
Immunosuppressed (equivalent of >15 mg/day of prednisone for >1 month or TNF-α antagonist)	□ Yes □ No
History of illicit drug use	□ Yes □ No
Resident, employee or volunteer in a high-risk congregate setting (correctional facilities, nursing homes, homeless shelters, hospitals or other healthcare facilities)	□ Yes □ No
Medical condition associated with increased risk of progression to TB disease if infected (diabetes mellitus, silicosis, head, neck or lung cancer, hematologic or reticuloendothelial disease such as Hodgkin's disease or leukemia, end stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight [10% or more below ideal for the given population])	□ Yes □ No

IF YES TO ANY QUESTION ABOVE, TB TESTING IS REQUIRED.

HEALTHCARE PROVIDER SECTION

If student has signs or symptoms of active TB, they must be treated and cured of TB before they can enroll at USC. A statement from the treating physician indicating treatment and cure is required. We will accept testing that has been done within the past 12 months.

NOTE TO INTERNATIONAL STUDENTS: *Interferon Gamma Release Assay is offered on campus at Student Health Services. You may have this completed when you arrive to South Carolina.*

Tuberculin skin test (TST) Result must be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0." The TST interpretation should be based on mm of induration as well as risk factors.

Date Given: ____/____/______ (mm dd yyyy)   Date Read: ____/____/_____ (mm dd yyyy)

Result: _______ mm induration   Interpretation: Negative ____ Positive ____

Interferon Gamma Release Assay (IGRA): Check the specific method: □ QFT-G □ TSPOT □ other

Date Obtained: ____/____/______ (mm dd yyyy)   Result: □ Negative □ Positive □ Indeterminate

Chest x-ray: Required if TST or IGRA is positive, or symptoms of active disease present. Attach a copy of the chest x-ray report to this document. We will accept a chest x-ray performed within the last three months.

Date of chest x-ray: ____/____/______ (mm dd yyyy)   Result: □ Normal □ Abnormal

Sputum evaluation: Required if symptoms of active TB disease are present. Attach a copy of the sputum report to this document.

Date performed: ____/____/______ (mm dd yyyy)   Result: □ Normal □ Abnormal

If TB test was positive, was INH prophylaxis completed? If so, dates: ____/____/______ (mm dd yyyy) until ____/____/______ (mm dd yyyy)

SECTION B : OPTIONAL IMMUNIZATIONS

The following vaccines are **strongly recommended, but are not currently required** for admission. They are available through Student Health Services for a fee.

1. **HPV (human papillomavirus**): Dose #1: ___/___/___ Dose #2 : ___/___/___ Dose #3 : ___/___/___

2. Hepatitis B: Dose #1: ___/___/___ Dose #2 : ___/___/___ Dose #3 : ___/___/___

3. Tetanus and diphtheria: T-dap: ___/___/___ or Td: ___/___/___

4. Hepatitis A: Dose #1: ___/___/___ Dose #2 : ___/___/___

5. **Varicella:** Dose #1: ___/___/___ Dose #2 : ___/___/___

OR history of chicken pox: ___/___/___
OR attach titer results: ___/___/___

6. IPV (inactivated poliovirus): Dose #1: ___/___/___ Dose #2: ___/___/___ Dose #3: ___/___/___ Dose #4: ___/___/___

Healthcare provider: (Signature or stamp required)

Name: ____ Signature:____
(Please Print)

Address: ____
Street / P.O. Box City State Zip Code

Phone: (______) ______________________________________ Date: ____

SECTION C: PARENTAL CONSENT (if student is under age 16)

I hereby authorize any medical treatment and/or counseling services for my son/daughter that may be advised or recommended by the healthcare providers and/or counselors at the University of South Carolina.

Parent Signature: ____Date:_________________________________

SECTION D: IMMUNIZATION EXEMPTIONS

□ This student is exempt from the above immunizations on grounds of permanent medical contraindication.
Attach verification from healthcare provider.
□ This student is temporarily exempt from the above immunizations until ___/___/___.
Attach verification from healthcare provider.
□ This student is exempt from the above immunizations on grounds of religious exemption.
Attach verification by religious leader or health department.

Distance Learning Exemption
I declare by my signature that I will **ONLY** be enrolling in courses offered by distance learning and therefore will not be attending **ANY** classes on the University of South Carolina–Columbia campus. I understand that registering for a course offered on campus or at a University-owned or controlled facility voids this exemption, and I will be excluded from class until I provide proof of immunizations. This exemption must be requested for each new term of registration for off-campus courses.

Student/parent or guardian signature ____