## **Immunization Form**



Return to the Records & Advisement Office

\_\_\_\_

Student Name	VIP ID
Cell Phone Number	Email
Address	
Date of Birth	Age
Student Signature	-
Section A - REQUIRED IMMUNIZATIONS Must Be Comp	leted and Signed By Your Health Care Provider.
1. M.M.R. (Measles, Mumps, Rubella) (two doses required for stud	
a. Dose 1 given at age 12-15 months or later	#1 / / M D Y
Dose 2 given at age 4-6 years or later, and at least one m <b>OR</b>	nonth after the first dose #2 / / M D _ Y
b. Laboratory/serologic evidence of immunity (attach copy o OR	of titer and date)
c. Exemption: I was born before 1957, and therefore am exer	mpt from this requirement
Year students (incoming freshman, under the age of 25) at the Un signature is required for students under the age of 18 if declining vaccinated with the Menomune, you should receive the Menactra with Menomune, then you are <b>required</b> to receive a Menactra vac <b>OR</b> Menactra Date of administration//	vaccine. If it has been between 2-5 years since you have been vaccine. If it has been more than 5 years since you have been vaccinated ccine or sign a waiver declining the vaccine.
Menomune Date of administration//	
Declined (signature required)	Date
<< <additional immunization="" requ<="" td=""><td>JIREMENT FOR INTERNATIONAL STUDENTS&gt;&gt;&gt;</td></additional>	JIREMENT FOR INTERNATIONAL STUDENTS>>>
<b>TUBERCULOSIS SCREENING</b> Are you a member of a high-risk group1 or are you entering the health If NO, You are not required to have a TB screening. If YES, you are requi vaccination should not preclude testing of a member of a high-risk grou	ired to have a TB screening. A history of BCG
1. Tuberculin Skin Test: Date Given://	Date Read://
M D Y Result:(Record actual mm of induration, trans Interpretation (based on mm if induration as well as risk fac	M D Y sverse diameter; if no induration, write "0") ctors): positivenegative
<ol> <li>Chest x-ray (required if tuberculin skin test is positive) result: no Date of chest x-ray://</li> <li>M D Y</li> </ol>	ormalabnormal
1Categories of high risk students include those students who have arrived within the past 5 years from countr Therefore, students should undergo TB screening if they have arrived from countries EXCEPT those on the fol Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco Australia, or New Zealand.	llowing list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia, USC, Virgin Islands (USA), Belgium,

Additional information on reverse

Gardasil - Highly recommended for all females between the ages 11 and 26. (Three doses of the cervical cancer vaccine)
DATE: #1// #2// #3//
M D Y M D Y M D Y
Hepatitis B – Highly recommended for all students. (Three doses of vaccine or a positive Hepatitis B surface antibody)
DATE: #1/ #2/ #3/, OR
M D Y M D Y M D Y 3 dose combined hepatitis A and hepatitis B series DATE #1// #2// #3// OR
M D Y M D Y M D Y M D Y Laboratory/serologic evidence of immunity or prior infection (attach copy of titer & date).
Varicella (Either a history of chicken pox, a positive Varicella antibody, or two doses of vaccine given at least
One month apart if immunized after age 13 years). History of Disease verified by undersigned clinician
$\square$ 1 dose given at 12 months of age or later but before the student's 13th birthdayDate of shot:/, <b>OR</b> M D Y
2 doses: Dose 1 given after the student's 13th birthday. 2nd dose at least one month after first dose, Date #1:
M D Y M D Y Tetanus-Diphtheria-Pertussis (Primary series with DTaP, DTP, DT, or Td, and booster with Td or Tdap in the last ten years).
1. Primary series of four doses with DTap, DTP, DT, or Td: DATE: #1// #2/ #3/ #4/
M D Y M D Y M D Y M D Y M D Y 2. Booster: Tdap (preferred) to replace a single dose of Td for booster immunization with at least five years since last dose of Td
M D Y 3. Booster: Td within the last ten years M D Y M D Y
Health Care Provider (Signature or stamp required)
Name:Signature:Sig
Address:
Phone: ()Date:
Section C – EXEMPTIONS
I,affirm by my signature below that immunization as required by the university of South Carolina conflicts with my religious beliefs. I understand that I am subject to exclusion from the University in the event of an outbreak of a disease for which immunization is required.
Signature: Date:
OR
Ideclare by my signature below that I will ONLY be enrolling in courses offered by distance learning, and therefore I will not be attending ANY classes on the USC campuses. I understand that registering for a course offered on-campus 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.
Signature: Date:

Sections A, B and C are to be signed, stamped and submitted to the Office of Records and Advisement.