University of South Carolina Beaufort Immunization Form

This form MUST be completed and returned to the Admissions Office by one of the following ways:

In Person or By U.S. Mail: USCB Admissions Office, One University Blvd, Bluffton, SC 29909

Document Photo or Scan Sent By Email: admissions@uscb.edu **-or-** **By Fax:** (843) 208-8290

Section A: Student Information (required for ALL students)

Name: _____ VIP ID: _____
Last *First* *M.I.*

Address: _____ Date of Birth: _____
Street / P.O. Box *MM / DD / YYYY*

_____ Age when entering USCB: _____
City *State* *Zip Code*

Phone: _____ Email: _____

First Tirm of Enrollment: ☐ Fall ☐ Spring ☐ Summer of year: _____

Student Signature: _____ Date: _____
By signing this document, I testify that the content is true and accurate. *MM / DD / YYYY*

Section B: Required Immunizations (required for ALL on-campus students)

Must be completed and signed by your health provider, or attach proof of your immunization history from a qualified health provider. Copies of original documents are acceptable.

1. **MMR (Measles, Mumps, Rubella): two doses required. Choose ONE of the following:**

   ☐ a. Dose 1 given at 12-15 months or later…….. Date: _____
   AND Dose 2 given at 4-6 years or later, at least one month after first dose…….. Date: _____
   -OR-
   ☐ b. Laboratory/serologic evidence of immunity (attatch copy of titer results and date)
   -OR-
   ☐ c. Exemption: I was born before 1957, and therefore am exempt from this requirement.

2. **MCV4 (Meningitis): vaccine or signed waiver is required for all students under age 21. If the first dose is before age 16, a booster is also required. Choose ONE of the following:**

   ☐ a. Dose 1 given **before** age 16…….. Date: _____
   AND Booster given after age 16***…….. Date: _____
   ****If booster was not received, please also sign the decline waiver below*
   -OR-
   ☐ b. Dose 1 given **after** age 16…….. Date: _____
   -OR-
   ☐ c. I have read the CDC recommendations for the Meningococcal vaccine and I am declining to receive the vaccine and/or the booster (signature required):

   Declined Signature: _____ Date: _____

Section C: Additional Immunizations Required for International Students

Turberculosis Screening

Are you a member of a high-risk group[1] or are you entering the health professions? ☐ Yes ☐ No

If "no," you are not required to have a TB screening. If "yes," you are required to have a TB screening. A history of BCG vaccination should not preclude testing of a member of a high-risk group. BCG is not acceptable to meet requirement.

1. Tuberculin Skin Test:
   Date Given: _____ Date Read: _____
   MM / DD / YYYY *MM / DD / YYYY*

   Result: _____ (Record actual mm of induration, transverse diameter; if no induration, write "0")

2. Chest X-Ray (required if tuberculin skin test is positive) result: ☐ Normal ☐ Abnormal
   Date of chest x-ray: _____
   MM / DD / YYYY

Section D: Recommended Immunizations

Gardasil – Highly recommended for all females between the ages of 11 and 26 (three cervical cancer vaccine doses).

☐ 3 dose Gardasil series

Date #1: ___/___/___ Date #2: ___/___/___ Date #3: ___/___/___
MM DD YY *MM DD YY* *MM DD YY*

Hepatitis B – Highly recommended for all students. (Three doses of vaccine or a positive Hepatitis B surface antibody)

☐ 3 dose Heptatitis B series

Date #1: ___/___/___ Date #2: ___/___/___ Date #3: ___/___/___
MM DD YY *MM DD YY* *MM DD YY*

-OR-

☐ 3 dose combined Hepatitis A and Hepatitis B series

Date #1: ___/___/___ Date #2: ___/___/___ Date #3: ___/___/___
MM DD YY *MM DD YY* *MM DD YY*

-OR-

☐ Laboratory/serologic evidence of immunity or prior infection (attach copy of titer & date)

Tetanus-Diptheria-Pertussis (Primary series with DtaP, DTP, DT or Td, & booster with Td or Tdap in the last ten years)

☐ Primary series of four doses with DtaP, DTP, DT, or Td:
Date #1: ___/___/___ Date #2: ___/___/___ Date #3: ___/___/___ Date #4: ___/___/___
MM DD YY *MM DD YY* *MM DD YY* *MM DD YY*

☐ Booster: Tdap (preferred) to replace a single dose of Td for booster immunization with at least five years since last dose of Td……Date: ___/___/___
MM DD YY

☐ Booster: Td within the last ten years……Date: ___/___/___
MM DD YY

[1] Categories of high risk students include those students who have arrived within the past 5 years from countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Therefore, students should undergo TB screening if they have arrived from countries EXCEPT those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia, USA, Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, or New Zealand.

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)

☐ History of disease verified by undersigned clinician…….. Disease date: ___/___/___
MM DD YY

-OR-

☐ Laboratory/serologic evidence of immunity (attach copy of titer & date)

-OR-

☐ 1 dose given at 12 months of age or later, but before student's 13th birthday…… Date: ___/___/___
MM DD YY

-OR-

☐ 2 doses. Dose 1 given after the student's 13th birthday, dose 2 given at least one month after first dose.

Date #1: ___/___/___ Date #2: ___/___/___
MM DD YY *MM DD YY*

Health Care Provider (Signature or stamp required)

Name: _____ Signature: _____
(Please Print)

Address: _____
Street/P.O. Box

_____
City *State* *Zip*

Phone: (_____) _____ Date: _____

Section E: Exemptions for Immunization Requirements

Physical or Religious Exemption

☐ I am exempt from the above immunization on grounds of permanent medical contradiction
☐ I am temporarily exempt from the above immunizations until ___/___/___ (written explanation required)
☐ Immunizations are in conflict with my religious beliefs.

I, _____, affirm, by my signature below, that I am exempt from the immunizations as required by the University of South Carolina Beaufort. I understand that I am subject to exclusion from the University in the event of an outbreak of a disease for which these immunizations are required.

Signature: _____ Date: _____

Online Student Exemption

I, _____, affirm, 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 USCB campuses. I understand that registering for a course offered on-campus or at a University owned or controlled facility will void this exemption, and I will be excluded from class until I provide proof of immunizations.

Signature: _____ Date: _____