Charleston Southern University

Department of Residence Life

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Immunization Record
(A.-F. Required for Residence Hall Assignment)
Please maintain copy of form for your personal records.

Print Name: _____

Student ID#: _____ Date of Birth: ___/___/___

University policy requires students to have the following immunizations for their protection prior to admittance to the Charleston Southern University Residence Halls. **All information (A-F) is required and must be in English and completed, dated, and signed by your Health Care Provider. Parental signatures are not accepted.**

Required

A. **M.M.R.** (Measles, Mumps, Rubella) (Two Doses Required)
#1 ____ / ____ #2 ____/____
Mo Yr Mo Yr

B. **Tetanus-Diphtheria** (Primary series with DtaP or DTP and booster with Td in the last ten years meets requirements.)

Primary series with four doses with DtaP or DTP
#1 ____ / ____ #2 ____/____ #3 ____/____ #4 ____/____
Mo Yr Mo Yr Mo Yr Mo Yr
And
#2 Tetanus-Diphtheria (Td/Tdap) Booster within last ten years ____/____
Mo Yr

C. **Polio** (Primary series in childhood meets requirement; three primary series scheduled are acceptable.)
#1 ____ / ____ #2 ____/____ #3 ____/____
Mo Yr Mo Yr Mo Yr

D. **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 meets the requirement
1. **History of Disease** Yes ____ No ____ Year _____
Or
2. **Varicella Antibody** ____/____ Reactive _____ Nonreactive ____
Or
3. **Vaccine** _____/_____
Two doses required if immunized after age 13.
First Dose: ____/____ Second Dose ____/_____

E. **Hepatitis B** (Three doses or a positive Hepatitis surface antibody meets the requirement.) A minimum of Dose #1 of the Hepatitis B immunization must be received prior to moving into the residence halls. Doses #2 and #3 must be completed prior to the end of the first semester for students to be able to continue living in the residence halls.
1. **Immunization** #1 ____ / ____ #2 ____/____ #3 ____/____
Mo Yr Mo Yr Mo Yr
or
2. **Hepatitis B surface antibody** ___ / ____ Reactive ___ Nonreactive ___
Mo Yr

F. **Tuberculosis Screening** (within the past 12 months)
1. **PPD (Mantoux) _____ or Quantiferon _____**
Result: Neg___ Pos___ Abnormal___
Date of Test: Month _____ Year _____
2. **If screening is positive, chest X-ray required:**
X-ray result: Normal ___ Abnormal___
Date of Test: Month ____ Year ____

Recommended

A. **Influenza** (Annual immunization recommended to avoid disruption to academic activities.)
Month ____ / Year ____

B. **Meningococcal** (MCV4: Menactra or Menveo): A booster dose is recommended if the previous dose was given before the age of 16. If an initial dose was given after the age of 16, no booster dose is recommended.
Meningococcal #1 ___/___/___ Booster Meningococcal ___/___/___

C. **Covid 19** – Manufacturer _____
#1 _____/_____ #2 _____/_____ Booster _____/_____

Note: Proof of receipt of immunizations A-F is required and must be on file at the University before your housing assignment can be completed.

I certify that the preceding information is correct to the best of my knowledge.
Health Care Provider Signature (Licensed Physician, Registered Nurse, Health Care Agency – Parent / Student signature not acceptable.

Signature: _____ Date: _____

Print Name: _____

Address: _____

Phone: ( ) _____ - _____

Please maintain copy of form for your personal records.