Charleston Southern University

Department of Residence Life
9200 University Blvd. North Charleston SC 29406

Student Immunization Record --- **Required before Residence Hall Assignment**

Print Name		**Date of Birth**	
Student ID#		**CSU Start Date**	

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

Required Vaccines	**Doses**	**Date**	**Date**	**Date**	**Date**
M.M.R. (Measles, Mumps, Rubella)	2	/ /	/ /		
Hepatitis B	3	/ /	/ /	/ /	
Tetanus-Diptheria *(primary series and booster)*	4	/ /	/ /	/ /	/ /
Tetanus-Diptheria Booster (Td/Tdap) **(*must be within last 10 years)***		/ /	/ /		
Varicella (one dose if vaccinated before age 13)	1	/ /	Booster		/ /
***OR* History of Disease**	Yes ____ No ____		Year _____		
OR Antibody titer	Reactive: Yes ____ No ____			Date of Test:	
Recommended Vaccines		**Date**	**Date**	**Date**	**Date**
Polio	3	/ /	/ /	/ /	
Meningococcal Vaccine MCV4: (Menactra or Menveo) Booster dose required if the previous dose was given before age 16.	1	/ /	Booster		/ /
HPV (Human Papillomavirus)	3	/ /	/ /	/ /	
COVID-19		/ /	/ /	/ /	/ /
Influenza	annual	/ /	/ /	/ /	/ /

TB Screening for International Students who were born in or who frequently travel to countries where TB disease is common, including, but not limited to Mexico, the Philippines, Vietnam, India, China, Haiti, Guatemala, or other countries with high rates of TB. Students who have received the BCG Vaccine do not have to submit a TB screening.

		Date	**Results**	
BCG Vaccine	1	/ /		
TB screening (within the last 12 months) *(screening can be PPD or Quantiferon)*	1	/ /	POS_____	NEG___
If TB screening is positive, a chest x-ray is required		/ / X-ray: Normal _____ Abnormal _____		

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) required. Parent or student signatures are not acceptable.

Signature: _____ Date: _____

Print Name: _____Title: _____ Phone Number: _____

Address: _____

Please maintain a copy of this form for your personal records. Copies will not be available to you in the future.