

UNIVERSITY OF SOUTH CAROLINA SCHOOL OF MEDICINE

Immunization Requirements

If you have questions concerning immunization requirements,
contact Jennifer Evans by phone: 803.216.3374 or email: Jennifer.evans@uscmed.sc.edu.

- ❑ **HEALTH CARE PROVIDER:** A licensed healthcare provider must complete the immunization form. A health care provider is: a physician licensed to practice (M.D. or D.O.), a Licensed Nurse, or a Public Health Official.
- ❑ **ENGLISH:** All information **must be submitted in English.**
- ❑ **MEASLES, MUMPS, RUBELLA:** Documentation of **two doses of MMR vaccine is required** for students born after January 1, 1957. A copy of laboratory report(s) in English with evidence of immunity (IgG) to Measles, Mumps, and Rubella may be submitted in place of immunization records.
- ❑ **HEPATITIS B:** Students must receive the full Hepatitis B immunization series prior to beginning classes (3 shots at 0, 1-2, and 6 months). **They must also provide documentation of immunity (Hepatitis B surface antibody).** Students who would like to refuse the hepatitis B series may do so by filling out an informed refusal form. They can obtain this from the Employee/Student Health Office. (Hepatitis B immunization is **STRONGLY** encouraged unless contraindicated.) **In some cases Hepatitis B vaccine booster may need to be given if titer is negative. In addition a repeat surface antibody titer is required.**
- ❑ **VARICELLA:** Students must present proof of immunity to Varicella (chicken pox) by laboratory documentation of immunity (IgG) to varicella. Students who have not previously been immunized and who do not have laboratory proof of immunity should complete the two-dose vaccination series followed by a Varicella IgG titer. **History of illness is not accepted.**
- ❑ **TDAP:** Students must provide documentation of one dose of Tdap (tetanus, diphtheria, acellular pertussis) immunization as an adult. This became available in June 2006. Tdap immunizations are only good for 10 years!
- ❑ **TUBERCULOSIS SCREENING:** 2 step PPD is required. The 2 step PPD is 2 PPD's test. The first test is administered and read 48-72 hours after placement. The second PPD is placed at least 1 week after the first test but no more than 3 weeks from the first test. The second PPD must also be read 48-72 hours after placement. Screening for tuberculosis exposure is a tuberculin skin test performed within the last 3 months. Students with a previous history of a positive tuberculosis skin test must submit (1) written documentation of the previous positive test, (2) a completed TB Symptom Survey (available from the Student Health Office) and (3) a chest X-ray report obtained within two years of school entry. Skin testing is not necessary for these students. Please note that a history of the BCG vaccine is not contraindicated for TB skin testing.
- ❑ **INFLUENZA VACCINE:** Students must provide documentation of one dose of Influenza Vaccine during the months of flu season (September – March). This is a **MANDATORY** vaccine. Medical and Religious exemptions may be granted. These forms are available in the Student Health Office.
- ❑ **EXEMPTIONS:** There are exemptions for some of the above requirements, as described below.
 - **MEDICAL CONTRAINDICATIONS:** Students are not required to receive immunizations for which they are medically contraindicated. The health care provider should attach a short statement to describe medical contraindications to any of the required immunizations. This statement will be accepted only if it meets the standards of care at The University of South Carolina School of Medicine.
 - **PREGNANCY OR SUSPECTED PREGNANCY:** Some immunizations are contraindicated during pregnancy. The student must submit a signed statement from a physician stating the student is pregnant or pregnancy is suspected. Pregnancy exemptions are applicable only to Measles, Mumps, Rubella and Varicella vaccination requirements. Submit this statement to the Student Health Office.
 - **AGE EXEMPTION:** Persons born before January 1, 1957 are considered immune to Measles, Mumps, and Rubella. Requirements may be met by the submission of a copy of the student's birth certificate, driver's license, or passport identifying the birth date. Submit this statement to the Student Health Office.
 - **Please note that anyone with a vaccine exemption may be excluded from the University/College in the event of a Measles, Mumps, Rubella, Varicella or Diphtheria outbreak in accordance with public health law**

UNIVERSITY OF SOUTH CAROLINA SCHOOL OF MEDICINE IMMUNIZATION FORM

Last Name: _____ First Name: _____ DOB: ____/____/____

Address: _____

Phone Number: _____ Anticipated Graduation Year: _____

Instructions: Please have a Health Care Provider (physician, nurse, or physician assistant) certify this form by signing the bottom. If the requested immunization information is not available for a condition, serologic proof of immunity may be submitted instead. Laboratory reports **MUST** be attached.

Policy of Viral Hepatitis and HIV/AIDS: The USC SOM does not require testing for HIV or viral hepatitis. However, knowledge of one's own HIV and Hepatitis status is strongly encouraged for students/employees who will be performing invasive procedures that might put patients or other persons at risk of infection, and have reason to believe they may have been exposed to these infections. The USC SOM does not discriminate against students on the basis of Hepatitis or HIV infection. However, students/employees who know they are infected with HIV or Hepatitis or believe they may be infected with HIV have an ethical obligation to disclose this information so that appropriate duty modifications can be made.

MMR- Documentation of 2 doses of MMR vaccine is required for individuals born after January 1, 1957. A copy of laboratory report(s) in English with evidence of immunity to Measles, Mumps, and Rubella may be submitted in place of immunization records.

<u>Option 1</u>		<u>Option 2</u>			
Vaccine	Date	Laboratory Report	Date	Results	Copy Attached
MMR Dose #1	____/____/____	Measles IgG Titer	____/____/____	_____	○ ○ ○
MMR Dose #2	____/____/____	Mumps IgG Titer	____/____/____	_____	
		Rubella IgG Titer	____/____/____	_____	

Hepatitis B - Documentation of the full Hepatitis B immunization series (3) must be submitted ALONG WITH documentation of immunity by a hepatitis B surface antibody titer. If the Hepatitis B Surface Antibody Titer shows that there is no evidence of immunity, a booster dose should be given and then a repeated titer in 1-2 months. If second antibody is negative, booster #2 & #3 should be administered with repeat titer after 3rd dose. If surface antibody still nonreactive, Hep B Surface Antigen should be drawn and documentation submitted.

<u>Primary Series</u>		<u>Boosters</u>		<u>After 3 boosters:</u>	
Hep B Dose #1	____/____/____	Hep B Booster #1	____/____/____	Hep B Surface Antibody	____/____/____
Hep B Dose #2	____/____/____	Hep B Surface Antibody	____/____/____	<i>Please attach copy</i>	
Hep B Dose #3	____/____/____	If surface antibody nonreactive after 1 booster:		If surface antibody nonreactive after 3 boosters:	
Hep B Surface Antibody	____/____/____	Hep B Booster #2	____/____/____	Hep B Surface ANTIGEN	____/____/____
Results of Titer	_____ mIU/ml	Hep B Booster #3	____/____/____	Results of Titer	_____ mIU/ml
<i>Please attach copy</i>		<i>Please attach copy</i>		<i>Please attach copy</i>	

TDaP - Must provide one dose of adult TDaP. If last TDaP was given more than 10 years ago, provide date of last TD AND TDaP

TDaP Vaccine	____/____/____	TD Vaccine	____/____/____
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Varicella (Chicken Pox) - Varicella (Chicken Pox) - Documentation of 2 doses of Varicella vaccine is required. A copy of laboratory report(s) in English with evidence of immunity to Varicella may be submitted in place of immunization records.

<u>Option 1</u>		<u>Option 2</u>			
Vaccine	Date	Laboratory Report	Date	Results	Copy Attached
Varicella Dose #1	____/____/____	Varicella IgG Titer	____/____/____	_____	○
Varicella Dose #2	____/____/____				

Tuberculosis Screening - The second ppd should be no sooner than one week of the first ppd and no later than three weeks of the first ppd. If you have a history of a positive PPD, a chest x-ray done in the U.S. within the past 2 years is required along with the submission of a TB symptom survey, positive PPD result and DHEC documentation

<u>PPD</u>			<u>IGRA</u>		
Date Placed	Date Read	Interpretation	Date Drawn	Interpretation	Copy Attached
____/____/____	____/____/____	_____ mm _____ mm	____/____/____	<input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate	○
<u>CXR</u>	<u>TB Symptom Survey</u>				
Date	Interpretation	Date	Copy Attached		
____/____/____	<input type="checkbox"/> Negative <input type="checkbox"/> Positive	____/____/____	○		

Recommended Immunizations (not required)

Meningococcal Vaccine	____/____/____	____/____/____	Hepatitis A Vaccine	____/____/____	____/____/____
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Please list Allergies or Contraindications to Immunizations (may provide separate sheet if needed)

INFORMATION ON CERTIFYING HEALTH CARE PROVIDER (PHYSICIAN, NURSE, OR PHYSICIAN ASSISTANT)

Name: _____ Degree: _____

Signature: _____ Date: _____

Address: _____ Phone: _____