



# MUSC VISITING STUDENT IMMUNIZATION REQUIREMENTS

NAME: \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ PHONE \_\_\_\_\_  
 PROGRAM: \_\_\_\_\_ DATES @ MUSC: \_\_\_\_\_

**MANDATORY IMMUNIZATIONS & INSURANCE REQUIREMENTS:** Verification of the following immunizations by a health care professional is required for **ALL VISITING** students prior to arrival to MUSC. Students will not be cleared for rotations or to be on campus if these requirements are not completed as indicated. Please note that copies of other immunization records may not be substituted for this MUSC IMMUNIZATION REQUIREMENTS form, but may be attached.

**ALL STUDENTS MUST PROVIDE PROOF OF HAVING ACTIVE HEALTH INSURANCE.**

**INSTRUCTIONS FOR HEALTH CARE PROVIDER CERTIFYING IMMUNIZATION RECORDS:**

- Positive/Immune IgG Antibody Titers are the preferred proof of immunity for Measles, Mumps, Rubella and Varicella. Copies of actual lab reports with values/indices/reference ranges, etc. must be attached to this form. NOTE: Computer print-out of titer results from employee/student immunization program is not acceptable. Re-vaccination may be required for IgG Antibody Titers that are not positive/immune. In lieu of positive/immune antibody titers, appropriate documentation of MMR (as required by date of birth)\* and Varicella vaccines are accepted.
- Verification must be in **ENGLISH & LEGIBLE**.
- All dates must include the month, day, year (mm/dd/yy).
- Each vaccine date must have the signature/stamp of the healthcare professional/facility verifying the vaccination.

**UNACCEPTABLE AS PROOF OF IMMUNIZATION:**

- Partial dates – must include month/day/year (mm/dd/yy)
- Initials – must be legible signature & title or office stamp
- NO PARENTAL SIGNATURES

**MEDICAL CONTRAINDICATION TO REQUIRED VACCINES:**

- Written statement is required from physician indicating the adverse reaction or medical circumstances for which immunization is not considered safe.

<b>1. TB SKIN TEST</b> <input type="checkbox"/> Use separate MUSC Form: "TUBERCULOSIS SCREENING" <b>Be sure to attach required documentation and Chest X-Ray report (if applicable) as indicated</b>			
<b>2. MEASLES (Rubeola), MUMPS, RUBELLA (German Measles)</b> <input type="checkbox"/> POSITIVE / IMMUNE IgG Antibody Titers or MMR Vaccines as indicated below			
*Students born <b>on or after 01/01/1957</b> : Positive/Immune IgG MMR Titers <u>or</u> <b>TWO MMR</b> Vaccines received on or after age of 12 months AND both after 12/31/67			
*Students born <b>on or before 12/31/1956</b> : Positive/Immune IgG MMR Titers <u>or</u> <b>ONE MMR</b> Vaccine received after 12/31/67			
<b>ANTIBODY TITER</b>	<b>MONTH / DAY / YEAR</b>	<b>TITER RESULTS : Negative / Equivocal / Borderline / Indeterminate Titers require vaccination if indicated</b>	
Measles / Rubeola IgG		<input type="checkbox"/> Positive / Immune	<input type="checkbox"/> Equivocal / Borderline
Mumps IgG		<input type="checkbox"/> Positive / Immune	<input type="checkbox"/> Equivocal / Borderline
Rubella IgG		<input type="checkbox"/> Positive / Immune	<input type="checkbox"/> Equivocal / Borderline
		<input type="checkbox"/> Negative / Non-Immune	<input type="checkbox"/> Lab Report Attached
<b>MMR VACCINES</b>	<b>MONTH / DAY / YEAR</b>	<b>LEGIBLE SIGNATURE or STAMP of HEALTHCARE PROFESSIONAL / FACILITY VERIFYING EACH VACCINATION</b>	
#1 Measles-Mumps-Rubella			
#2 Measles-Mumps-Rubella			
<b>3. VARICELLA (CHICKEN POX)</b> <input type="checkbox"/> POSITIVE / IMMUNE IgG Antibody Titer <u>or</u> 2 Varivax Vaccines as indicated below			
<b>ANTIBODY TITER</b>	<b>MONTH / DAY / YEAR</b>	<b>TITER RESULTS : Negative / Equivocal / Borderline / Indeterminate Titer requires vaccination if indicated</b>	
Varicella IgG Titer Date:		<input type="checkbox"/> Positive / Immune	<input type="checkbox"/> Equivocal / Borderline
		<input type="checkbox"/> Negative / Non-Immune	<input type="checkbox"/> Lab Report Attached
<b>VARICELLA VACCINES</b>	<b>MONTH / DAY / YEAR</b>	<b>LEGIBLE SIGNATURE or STAMP of HEALTHCARE PROFESSIONAL / FACILITY VERIFYING EACH VACCINATION</b>	
#1 Varivax			
#2 Varivax			
<b>4. TETANUS</b> <input type="checkbox"/> Adult Tetanus/ Diphtheria on or after 8/01/2001. Due to the increased risk of pertussis ("whooping cough") in healthcare settings, the Advisory Committee on Immunization Practices recommends Tdap (Tetanus - Diphtheria - Acellular Pertussis) for all healthcare personnel. Tdap is <u>highly recommended</u> if it has been more than 2 years since the last Tetanus/Diphtheria (TD) vaccine.			
<b>TETANUS VACCINES</b>	<b>MONTH / DAY / YEAR</b>	<b>LEGIBLE SIGNATURE or STAMP of HEALTHCARE PROFESSIONAL / FACILITY VERIFYING EITHER VACCINATION</b>	
Tetanus/Diphtheria/Pertussis			
Tetanus/Diphtheria			
<b>5. SEASONAL FLU VACCINE</b> <input type="checkbox"/> REQUIRED FOR MUSC AFFILIATION DURING THE MONTHS OF JANUARY, FEBRUARY, MARCH AND APRIL			
	<b>MONTH / DAY / YEAR</b>	<b>LEGIBLE SIGNATURE or STAMP of HEALTHCARE PROFESSIONAL / FACILITY VERIFYING EITHER VACCINATION</b>	
Seasonal Flu Vaccine			
<b>6. Hepatitis B Vaccine Series:</b> Required for individuals who may have direct patient contact.			
#1	#2	#3	Hepatitis B Antibody Titer: _____
MONTH / DAY / YEAR	MONTH / DAY / YEAR	MONTH / DAY / YEAR	(Attach copy of Lab Report to MUSC form)



Student Health Services  
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Charleston, South Carolina 29425

# TUBERCULOSIS SCREENING

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

## Self-Evaluation Survey for Tuberculosis

ALL STUDENTS MUST COMPLETE THIS SECTION

Do you currently have any of the following chronic conditions:

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough (> 3 weeks)	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	<input type="checkbox"/>	Chronic fatigue (> 3 weeks)	<input type="checkbox"/>	<input type="checkbox"/>	Unexpected weight loss
<input type="checkbox"/>	<input type="checkbox"/>	Chronic chest discomfort	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats (excluding menopause)
<input type="checkbox"/>	<input type="checkbox"/>	Persistent low grade fever	<input type="checkbox"/>	<input type="checkbox"/>	Poor appetite
<input type="checkbox"/>	<input type="checkbox"/>	Coughing up sputum or blood	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Infections

SIGNATURE of STUDENT: \_\_\_\_\_ Date: \_\_\_\_\_

**NOTE:** Students with a history of a **Previously Positive TB Skin Test\*** must provide documentation by completing the information in the last section of the "Two Tuberculin Skin Tests - Intradermal Purified Protein Derivative" below and are required to complete a **Self-Evaluation Survey for Tuberculosis** annually in lieu of TB Skin Testing.

## TWO TUBERCULIN SKIN TESTS - Intradermal Purified Protein Derivative (PPD)

**TWO PRE-MATRICULATION TB SKIN TESTS (Intradermal PPD - Mantoux 5TU) within 12 months of MUSC Affiliation according to the following procedure & instructions:**

**1st PPD (Mantoux 5TU) -**

Date Given: \_\_\_\_\_ Date Read: \_\_\_\_\_ Results: \_\_\_\_\_ mm induration\*\* \_\_\_\_\_ mm erythema  
(RECORD RESULTS IN "mm" ONLY, NOT "NEGATIVE" OR "POSITIVE")

SIGNATURE / STAMP OF MD, NURSE, HEALTH CARE FACILITY: \_\_\_\_\_

**\*\* If 1st PPD is non-reactive (0mm induration) or intermediate (1-9mm induration), proceed to 2nd PPD.**

**2nd PPD (Mantoux 5TU) - Placed on the opposite forearm 7-10 days after 1st TB Skin Test**

Date Given: \_\_\_\_\_ Date Read: \_\_\_\_\_ Results: \_\_\_\_\_ mm induration\*\* \_\_\_\_\_ mm erythema  
(RECORD RESULTS IN "mm" ONLY, NOT "NEGATIVE" OR "POSITIVE")

SIGNATURE / STAMP OF MD, NURSE, HEALTH CARE FACILITY: \_\_\_\_\_

**\*\*\* If either 1st PPD or 2nd PPD ≥ 10mm induration, a CHEST X-RAY is required to rule out active TB:**

Date of CHEST X-RAY: \_\_\_\_\_ Result: \_\_\_\_\_ (copy of X-Ray Report required)

**\* If you have a history of a PREVIOUSLY RECORDED TB SKIN TEST, a chest X-Ray taken after the skin test was documented as positive is required:**

Date of Positive TB Skin Test: \_\_\_\_\_ Date of Chest X-Ray: \_\_\_\_\_ Result: \_\_\_\_\_  
(ATTACH COPY OF DOCUMENTED POSITIVE TB TEST) (COPY OF CHEST X-RAY REPORT REQUIRED)

Prophylactic Treatment for Positive PPD:  No  Yes, treated x \_\_\_\_\_ months with:  INH  Other: \_\_\_\_\_