MEDICAL UNIVERSITY of SOUTH CAROLINA

Student Health Services
30 Bee Street – Suite 102
Charleston, SC 29425
Telephone 843-792-3664
Fax 843-792-2569

Visiting Students – Immunization Requirements

All MUSC students, including visiting students, are required to submit the following information. The Mandatory Immunization Requirements Form must be completed and signed or stamped by a licensed physician/nurse and received by Student Health Services before students will be allowed to attend classes.

Summary of Immunization Options

The summary below identifies the options for documenting compliance. **Please use the forms on the following pages for documentation and verification.**

Measles, Mumps, Rubella Immunity	Option A (recommended)	➡	Copy of Immune MMR IgG Antibody Titer lab report
	Option B for students born on or after	➡	Documentation of 2 MMR vaccines received on or after age of 12 months and both after 12/31/1967
	Option C for students born on or before 2/31/1956	➡	Documentation of 1 MMR vaccine received after 12/31/1967

Varicella Immunity	Option A	➡	Copy of lab report of Immune Varicella IgG Antibody Quantitative Titer
	Option B	➡	Documentation of two varicella vaccines (Varivax)
	Option C if titer is negative or equivocal	➡	Documentation of two varicella vaccines (Varivax)

Tetanus / Diphtheria/ Pertussis Vaccine	Required	➡	Adult Tdap on or after 6/10/2005
	Exception	➡	Documented Pertussis Allergy

Hepatitis B Immunity	Required	➡	Copy of lab report of positive Hepatitis B Surface Antibody Quantitative Titer

Flu Immunization	Required (Nov. 1 – April 30)	➡	Documentation of immuization

Tuberculosis Screening	Option A	➡	Documented baseline TB testing with 2-step intradermal TB testing (Mantoux 5 TU Tuberculin Skin Tests administered 7-10 days apart but no more than 90 days apart) **AND** TB Skin Test done every year after baseline testing, with the most recent annual test done within 12 months of rotation at MUSC
	Option B	➡	Interferon Gamma Release Assay (IGRA) Blood Test (QuantiFERON-TB Gold or T-SPOT) **AND** IGRA done every year after baseline testing, with the most recent annual test done within 12 months of rotation at MUSC
	Option C if previously positive TB Skin Test	➡	Documentation of the positive PPD (if no record, Option B required) and chest x-ray taken after positive PPD date

Last Name	______________________________
First Name	______________________________
Date of Birth (mm/dd/yy)	______________________________
Email address	______________________________
MUSC College/Program	______________________________
Dates on MUSC Campus	______________________________

Measles, Mumps, Rubella, Varicella Titers

Option A.

Antibody Titers	**Measles IgG Titer**
Month/Day/Year Of Titer	**____ / ____/ ____**
Titer Results (Check appropriate box)	❒ **Positive/Immune Titer Value ____________**
	❒ Equivocal/Borderline/Negative Titer Value ____________ (REQUIRES DOCUMENTATION OF TWO VACCINES – refer to page 2)
Additional requirement	Attach copy of lab report (mail to SHS with all Immunization Forms)

Antibody Titers	**Mumps IgG Titer**
Month/Day/Year Of Titer	____ / ____/ ____
Titer Results (Check appropriate box)	❒ Positive/Immune Titer Value ____________
	❒ Equivocal/Borderline/Negative Titer Value ____________ (REQUIRES DOCUMENTATION OF TWO VACCINES – refer to page 2)
Additional requirement	Attach copy of lab report (mail to SHS with all Immunization Forms)

Antibody Titers	**Rubella IgG Titer**
Month/Day/Year Of Titer	____ / ____/ ____
Titer Results (Check appropriate box)	❒ Positive/Immune Titer Value ____________
	❒ Equivocal/Borderline/Negative Titer Value ____________ (REQUIRES DOCUMENTATION OF TWO VACCINES – refer to page 2)
Additional requirement	Attach copy of lab report (mail to SHS with all Immunization Forms)

Antibody Titers	**Varicella IgG Titer**
Month/Day/Year Of Titer	____ / ____/ ____
Titer Results (Check appropriate box)	❒ Positive/Immune Titer Value ____________
	❒ Equivocal/Borderline/Negative Titer Value ____________ (REQUIRES DOCUMENTATION OF TWO VACCINES – refer to page 2)
Additional requirement	Attach copy of lab report (mail to SHS with all Immunization Forms)

Last Name	______________________________
First Name	______________________________
Date of Birth (mm/dd/yy)	______________________________
Email address	______________________________
MUSC College/Program	______________________________
Dates on MUSC Campus	______________________________

Option B. For students born on or after 01/01/1957 two MMR vaccines required and both after 12/31/1967; if born 12/31/1956 or before, One MMR vaccine received after 12/31/1967

Option C. REQUIRED if titer result(s) is equivocal/borderline or negative MMR / Varicella vaccines required.

MMR Vaccine	**Dose #1**	**Dose #2**
Month/Day/Year Of Vaccine	____ / ____/ ____	____ / ____/ ____
Signature (or stamp) of healthcare professional		
Address of healthcare professional/facility		
Telephone of healthcare professional/facility		

Varicella (Varivax) Vaccine	**Dose #1**	**Dose #2**
Month/Day/Year Of Vaccine	____ / ____/ ____	____ / ____/ ____
Signature (or stamp) of healthcare professional		
Address of healthcare professional/facility		
Telephone of healthcare professional/facility		

Tetanus/Diphtheria/Pertussis Vaccine

Required (Adult Tdap required on or after 6/10/2005)	
Month/Day/Year Of Vaccine	____ / ____/ ____
Signature (or stamp) of healthcare professional verifying vaccination	
Address of healthcare professional/facility verifying each vaccination	
Telephone of healthcare professional/facility verifying each vaccination	
❒ Exception: Documented pertussis allergy – Attach letter from healthcare provider detailing the nature of your reaction. (Leave on-line immunization form field blank if you have a documented pertussis allergy.)	

Last Name ______________________________

First Name ______________________________

Date of Birth (mm/dd/yy) ______________________________

Email address ______________________________

MUSC College/Program ______________________________

Dates on MUSC Campus ______________________________

Hepatitis B Vaccine Immunization

Hepatitis Antibody Titer (required)			
Month/Day/Year Of Titer	____ / ____/ ____		
Titer Results (Check appropriate box)	❒ Positive/Immune Titer Value ____________ ❒ Equivocal/Borderline/Negative Titer Value ____________ (REQUIRES DOCUMENTATION OF TWO VACCINES – see below)		
Additional requirement	Attach copy of lab report (mail to SHS with all Immunization Forms)		
Hepatitis B Vaccines (required if titer equivocal or borderline)	**Dose #1**	**Dose #2**	**Dose #3**
Month/Day/Year Of Vaccine	____ / ____/ ____	____ / ____/ ____	____ / ____/ ____
Signature (or stamp) of healthcare professional			
Address of healthcare professional/facility			
Telephone of healthcare professional/facility			

Flu Immunization

Required if on campus November 1 – April 30	
Month/Day/Year Immunization	____ / ____/ ____
Signature (or stamp) of healthcare professional	
Address of healthcare professional/facility	
Telephone of healthcare professional/facility	

Last Name ______________________
First Name ______________________
Date of Birth (mm/dd/yy) ______________________
Email address ______________________
MUSC College/Program ______________________
Dates on MUSC Campus ______________________

Tuberculosis Screening (Option A, B, or C)

Required: Documentation of baseline tuberculosis screening

Option A. Baseline	**#1 PPD**	Administered ___ / ___ / ___ Read ___ /___ /___	Report results in mm only; do not write "negative" or "positive" ______ mm induration ______ mm erythema * See below for additional requirement if ≥ 10mm induration	**Signature (or stamp)** healthcare professional **Address** **Telephone**
	#2 PPD Place on opposite forearm, 7 – 10 days after #1 PPD an no more than 90 days apart	Administered ___ / ___ / ___ Read ___ /___ /___	Report results in mm only; do not write "negative" or "positive" ______ mm induration ______ mm erythema * See below for additional requirement if ≥ 10mm induration	**Signature (or stamp)** healthcare professional **Address** **Telephone**
Option B. Baseline	**Quantiferon-TB Gold**	Test date ___ / ___ / ___	Result: ❐ Positive ❐ Negative	**REQUIRED - Attach copy of lab report**
Option C. Baseline	**T-SPOT**	Test date ___ / ___ / ___	Result: ❐ Positive ❐ Negative	**REQUIRED - Attach copy of lab report**

Required: Documentation of last annual TB surveillance within 12 months of rotation at MUSC

Most recent TB Skin test 5TU PPD	Administered ___ / ___ / ___ Read ___ /___ /___	Report results in mm only; do not write "negative" or "positive" ______ mm induration ______ mm erythema * See below for additional requirement if ≥ 10mm induration	**Signature (or stamp)** healthcare professional **Address** **Telephone**
Quantiferon-TB Gold	Test date ___ / ___ / ___	Result: ❐ Positive ❐ Negative	**REQUIRED - Attach copy of lab report**
T-SPOT	Test date ___ / ___ / ___	Result: ❐ Positive ❐ Negative	**REQUIRED - Attach copy of lab report**

MUSC
MEDICAL UNIVERSITY of SOUTH CAROLINA

Last Name ______________________________________
First Name ______________________________________
Date of Birth (mm/dd/yy) ______________________________________
Email address ______________________________________
MUSC College/Program ______________________________________
Dates on MUSC Campus ______________________________________

Required for students with a positive (≥ 10mm induration) TB skin test (current or previous)

Positive TB Skin Test	Month/Day/Year ___ / ___/ ___	______ mm induration
Chest x-ray	Month/Day/Year ___ / ___/ ____	Result:
REQUIRED DOCUMENTATION	**1. Attach copy documenting positive TB test** **2. Attach copy of x-ray report**	
Prophylactic Treatment for Positive PPD	❒ No ❒ Yes Treated ❒ INH ❒ Other ________ Treatment Dates: __/___/___ to ___/___/___ Start End	