MEDICAL UNIVERSITY OF SOUTH CAROLINA IMMUNIZATION VERIFICATION FOR VISITING STUDENTS

Name: ______________________________ **Social Security #** ______________________ **Date:** ____________

Date of Birth: ______________________________ **Department :** ______________________________

The following immunizations/tests are required for all visiting students/healthcare workers and are to be completed prior to their arrival to MUSC. Each immunization must be dated and signed or stamped by a Healthcare Professional / Facility. In addition, all students must provide proof of health insurance.

All attached records must be verifiable with the exact date of immunization and signed or stamped by a Healthcare Professional / Facility. Personal or parental signatures are not acceptable.

1. TB SKIN TEST – Use separate MUSC Form : "TUBERCULOSIS SCREENING"

Attach required documentation and Chest X-Ray report (if applicable) as indicated

2. MEASLES (Rubeola)**, MUMPS, RUBELLA** (German Measles) **: Positive IgG Antibody Titers or MMR Vaccine as indicated below**

Students born **on or after 01/01/57** are required to have: **Postive Measles IgG, Positive Mumps IgG, Positive Rubella IgG Titers***
or TWO MMR Vaccines received on or after age of 12 months **AND** both after 12/31/67

Students born **on or before 12/31/56** are required to have: **Postive Measles IgG, Positive Mumps IgG, Positive Rubella IgG Titers***
or ONE MMR Vaccine received after 12/31/67

TITER documentation: Negative or Equivocal (Borderline / Indeterminate) titers require additional MMR Vaccine

- ❑ **Measles IgG Antibody Titer Date:** ____________________ **Results:** ____________________________ (Copy of Lab Report is required. Attach to Immunization Record)
- ❑ **Mumps IgG Antibody Titer Date:** ____________________ **Results:** ____________________________ (Copy of Lab Report is required. Attach to Immunization Record)
- ❑ **Rubella IgG Antibody Titer Date:** ____________________ **Results:** ____________________________ (Copy of Lab Report is required. Attach to Immunization Record)

VACCINE documentation: Vaccination dates must include month / day / year

❑ **#1 MMR** (Measles, Mumps, Rubella) **Vaccine:** ________________________ (MONTH / DAY / YEAR) ____ (Signature / Stamp of MD, Nurse, Health Care Facility)

❑ **#2 MMR** (Measles, Mumps, Rubella) **Vaccine:** ________________________ (MONTH / DAY / YEAR) ____ (Signature / Stamp of MD, Nurse, Health Care Facility)

3. TETANUS: Adult Booster on or after 6-01-99. If your last booster was before6-01-99, a Tetanus / Diptheria / Pertussis (Tdap) is recommended as your 2008 booster. Vaccination documented must include month / day / year.

❑ **Tetanus / Diphtheria / Pertussis (Tdap)** ❑ **Tetanus / Diphtheria (Td)** ____________________ (MONTH / DAY / YEAR) ____ (Signature / Stamp of MD, Nurse, Health Care Facility)

**Due to the increased risk of pertussis in healthcare settings the Advisory Committee on Immunization Practices recommends Tdap for health care personnel.

4. VARICELLA (CHICKEN POX) : Positive Varicella IgG Titer or TWO Varicella Vaccines (Vaccination Dates must include month / day / year).

❑ **Varicella IgG Antibody Titer Date:** ______________________ **Results:** ____________________________ (Copy of Lab Report is required. Attach to Immunization Record)

If your Varicella IgG Antibody Titer is negative or equivocal (borderline), vaccination for Varicella (Chicken Pox) is required.

❑ **Varivax (Live Varicella Vaccine) #1** ________________________ (MONTH / DAY / YEAR) ____ (Signature / Stamp of MD, Nurse, Health Care Facility)

#2 ________________________ (MONTH / DAY / YEAR) ____ (Signature / Stamp of MD, Nurse, Health Care Facility)

5. Hepatitis B Vaccine Series: Required for direct patient contact that poses a risk of exposure to blood and body fluids ❑ **No Direct Contact**

#1 ____________________ (MONTH / DAY / YEAR) **#2** ____________________ (MONTH / DAY / YEAR) **#3** ____________________ (MONTH / DAY / YEAR) **Hepatitis B Antibody Titer:**________________________
(Attach copy of Lab Report to MUSC form)

I certify that the above information is correct and the individual named above meets all MUSC immunization / testing requirements as noted:

____ **Date:** ____________________
SIGNATURE / STAMP of HEALTHCARE PROFESSIONAL or FACILITY

STUDENT HEALTH SERVICES
MEDICAL UNIVERSITY of SOUTH CAROLINA
30-A BEE STREET
POST OFFICE BOX 250980
CHARLESTON, SOUTH CAROLINA 29425

TUBERCULOSIS SCREENING

NAME: ____ **DOB:** _____ / _____ / _____ **SSN** _______ – _____ – _________
FIRST MI LAST

PRE-MATRICULATION TB SKIN TEST (Intradermal PPD - Mantoux 5 TU): Within 3 months of MUSC Enrollment. Tine Test (Prong Test) not acceptable.

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: ____

*** Intermediate PPD (1-9 mm induration) requires 2nd PPD done 1 week after 1st PPD (should be placed on the opposite forearm)**

2nd PPD (if applicable as noted above)
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 ≥ 10 mm 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 POSITIVE 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** ___________________

**** You must complete and sign the Self-Evaluation Survey in the next section ▼**

▼ Self-Evaluation Survey for Tuberculosis Screening ▼

Students with a history of a **Previously Positive TB Skin Test** must complete a TB Screening Self-Evaluation Survey on admission to MUSC and annually thereafter. Do you currently have any of the following **chronic** conditions:

YES	NO		YES	NO	
☐	☐	Chronic cough (> 3 weeks)	☐	☐	Shortness of breath
☐	☐	Chronic fatigue (> 3 weeks)	☐	☐	Unexpected weight loss
☐	☐	Chronic chest discomfort	☐	☐	Night sweats (excluding menopause)
☐	☐	Persistent low grade fever	☐	☐	Poor appetite
☐	☐	Coughing up sputum or blood	☐	☐	Recurrent infections

____ _______________________
SIGNATURE of STUDENT DATE