SOUTH CAROLINA STATE UNIVERSITY • BROOKS HEALTH CENTER

IMMUNIZATION FORM

PART I: Personal Information

Last name (print) _____ First _____ Middle_____
South Carolina State University ID number _____ Date of Birth _____
Permanent address _____
City _____ State/Country _____ Zip code_____
Telephones: Home (_____) _____ Cell (_____) _____
Email (SCSU) _____First Term of Enrollment (Month/Year) _____

PART II: Required Immunizations

This information is true and accurate to the best of my knowledge. All information MUST be in English.

1. Measles/Mumps/Rubella (MMR) (2 doses required)

1. Dose #1: (Date) _____ /_____ /_____ given at age 12 months or later)
2. Dose #2: (Date) _____ /_____ /_____ given 2nd dose must be 28 days after first dose
*** OR Attach copy of Laboratory Results**

2. Meningococcal Vaccine: Proof of a meningococcal vaccine Quadrivalent A, C, W ,Y] (Menactra, Menomune, Menveo) or Serogroup B vaccine (Bexsero, Trumenba) or a signed waiver declining the vaccine is required of all incoming students under 25 years of age living in residence halls. If declining this vaccination, a parent/legal guardian's signature is required for students under the age of 18. Revaccination is recommended every five years.

Meningococcal Vaccine (Date) _____ /_____ /_____ Menactra (Date) _____ /_____ /_____
Menomune (Date) _____ /_____ /_____ Menveo (Date) _____ /_____ /_____
Bexsero (Date) [#1] **_____ /_____ /_____ [#2] _____ /_____ /_____**
Trumenba (Date) [1] _____ /_____ /_____ [#2] _____ /_____ /_____ [#3] _____ /_____ /_____

☐ **Declined Meningococcal Vaccination _____ Date _____**
(Signature Required)
PRINT Name _____ Date _____
Parent/Legal Guardian Signature _____ Date _____
(Parent/Legal guardian signature required if student is under the age of 18)

PART III: Recommended Immunizations:

1. Hepatitis A (2doses): [1] **_____ /_____ /_____ [2] _____ /_____ /_____**
2. Hepatitis B (3doses): [1] _____ /_____ /_____ [2] _____ /_____ /_____ [3] _____ /_____ /_____
3. Human Papillomavirus Vaccine (HPV) (HPV9-3 doses): [1] _____ /_____ /____ [2] ____ /_____ /____ [3] _____ /____ /_____
4. Influenza (flu): _____ /_____ /_____
5. Tetanus, Diphtheria, and Acellular Pertussis (Tdap or Td) Single dose within the last 10 years required for all students.

- **DTAP, DTP, DT, or TD (Date given) ____ /____ /____ Adacel (Date given) ____ /____ /____ Boostrix (Date given) ____ /_____ /_____**

***6.* Tuberculin (TB) SKIN Test (Mantoux Only) 0.1ml Intradermal** L or R forearm Date placed: _____/_____/_____
TB Test result: _____mm. induration: Neg. / Pos. Date read: _____/_____/_____

Signature of health care professional reading test _____
If TB test is positive, **CHEST X-RAY** must be obtained. **Send written report.** Date of X-ray: _____/_____/_____ and Plan of Care**. (Attach disposition)** _____

6. COVID-19 Vaccine (Pfizer) (Date) [1] _____ /_____ /_____ [#2] ___ /____ /____ [#3] ____ /____/____
Booster____ /____/____
(Moderna) (Date) [1] _____ /_____ /_____ [#2] ___ /____ /____ [#3] ____ /____/ _____
(Janssen) (Date) _____ /_____ /____

_____ _____
Physician/Nurse Practitioner/Physician Assistant /Signature Address

_____ Telephone Number _____ _____
City/State/Zip Code Phone Number Date

NOTE: This form will be retained by Brooks Health Center electronically! Please make a copy of this form before mailing the original!
RETURN FORM TO: SC State-Brooks Health Center; PO Box 7178; Orangeburg, SC 29117; (T) 803-536-7053; (F) 803-533-3747: email: BHC@scsu.edu

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