

**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: **Positive 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: **Positive 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: \_\_\_\_\_ Signature / Stamp of MD, Nurse, Health Care Facility
- #2 MMR (Measles, Mumps, Rubella) Vaccine: \_\_\_\_\_ Signature / Stamp of MD, Nurse, Health Care Facility

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

- Tetanus / Diphtheria / Pertussis (Tdap)       Tetanus / Diphtheria (Td) \_\_\_\_\_

\*\*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 \_\_\_\_\_ Signature / Stamp of MD, Nurse, Health Care Facility
- Varivax (Live Varicella Vaccine) #2 \_\_\_\_\_ 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 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_ Hepatitis B Antibody Titer: \_\_\_\_\_  
MONTH / DAY / YEAR      MONTH / DAY / YEAR      MONTH / DAY / YEAR      (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

## 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 2<sup>nd</sup> PPD done 1 week after 1<sup>st</sup> PPD (should be placed on the opposite forearm)

2<sup>nd</sup> 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 1<sup>st</sup> PPD or 2<sup>nd</sup> PPD  $\geq$  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

- Chronic cough (> 3 weeks)  
  Chronic fatigue (> 3 weeks)  
  Chronic chest discomfort  
  Persistent low grade fever  
  Coughing up sputum or blood

YES / NO

- Shortness of breath  
  Unexpected weight loss  
  Night sweats (excluding menopause)  
  Poor appetite  
  Recurrent infections

\_\_\_\_\_  
SIGNATURE of STUDENT

\_\_\_\_\_  
DATE