



Required Student Immunization Forms

Dear Student,

Welcome to Clemson University! We are glad you have chosen us to meet your higher education goals. Please complete and return the attached immunization forms. The University requires a complete immunization record for all students. Be certain to include your full name, date of birth, CUID and social security number. Complete the following forms and return prior to July 1 for Summer/Fall enrollment; December 1, for Spring enrollment.

Mail or fax to:

Redfern Health Center
Clemson University
Box 344054 Rm:61
Clemson, SC 29634-4054 Fax (864)656-0760

Guidelines for Completing Immunization Records

According to University policy, the immunization requirements must be met and on file at Redfern Health Center.

In order to avoid excessive waiting times, please have all of your immunization requirements completed and forms sent prior to your orientation date. If you are unable to obtain your records all required immunizations are available to you at Redfern Health center.

Acceptable records of your immunizations

- Personal shot records that are verified by a doctor's stamp or contain a health provider's signature
- Personal shot records with a clinic or health department stamp
- Military Records or World Health Organization (WHO) documents
- Previous college or university records that are verified. (please note that your immunization records do not transfer automatically, you must request a copy from your school)
- Positive laboratory test as confirmation of immunity

Be certain that your name, date of birth, Clemson University Identification number (CUID), or Social Security number appears on each sheet and that all forms are mailed together. Complete these forms in black ink. The dates of vaccine administration **must** include the month, day and year. All records must be in **English**. Please keep a copy for your own personal records.

SECTION A: Personal information

To be completed by the student. Please include all of the demographic information requested including name, address, date of birth, identifying information and **your signature**.

SECTION B: Required Immunizations

Have your physician or health department clinician fill in your immunization record and update any needed immunizations that are required in Section B. This form **must** be signed (section D) by an MD, PA, PA-C, FNP, FNP-C or stamped by the health department.

Tuberculosis screening is **required** for any student who has resided outside the U.S. within the past five years, **except** for the following countries: **Canada, Jamaica, Saint Kitts, Nevis, Saint Lucia, USA, Virgin Islands, Austria, Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, New Zealand.**

Students arriving from outside the U.S. are **required** to obtain this screening upon arrival to Clemson.

TB screening must be performed in the U.S., and is valid for one year.

TB screenings performed outside of the U.S. will not be accepted.

SECTION C: Recommended Immunizations

Certain academic departments and programs may require immunizations in addition to the minimum requirements for enrollment. Please consult with your individual academic departments for specifics on any additional requirements. Redfern Health Center, based on recommendations from the Centers for Disease Control and Prevention (CDC), and American College Health Association (ACHA) recommends receiving the immunizations listed in section C. You may elect to receive these immunizations from your private physician or health department prior to arriving at Clemson.

SECTION D: Health Care Provider Signature / Immunization Exemptions

Completion of this section by your healthcare provider is **required, including a signature or stamp**. Any medical contraindications are also documented in Section D. Please attach additional documentation of the medical need for an exemption to any immunization requirement.



A. TO BE COMPLETED BY THE STUDENT:

Name _____ CUID # _____
Last Name First Name Middle Name
Address _____ SSN _____
Street
City State Country Zip Code Date of Birth
Home Phone (____) _____ Cell Phone (____) _____ Email _____@clemson.edu
First term of Enrollment: Fall Spring Summer _____(year)
Student Signature _____ Date _____
By signing this document I testify that the content is true and accurate.

B. REQUIRED IMMUNIZATIONS: SECTIONS B,C,D must be completed and signed by your Health Care Provider:

- 1. **MMR (Measles, Mumps, Rubella)** Two doses required for all students born after 1956
 Dose 1 given age 12 months or later..... / /
Month Day Year
 Dose 2 given at least one month after first dose..... / /
Month Day Year
 EXEMPTION, BORN BEFORE 1957

A positive MMR titer result may be submitted in lieu of vaccination history (attach copy titer result)

- 2. **Tdap (tetanus, diphtheria, and acellular pertussis)** Single dose required for all students age 64 years or younger
/ /
Month Day Year

- 3. **MENINGOCOCCAL VACCINE** Proof of a conjugate meningococcal vaccine (e.g. Menactra, Menveo) or a signed waiver declining the vaccine is required of all entering students age 21 years or younger. If vaccine was received prior to age 16, a booster is **required**. **A parent/legal guardian's signature is required if students under the age of 18 decline this vaccination.**

MENVEO (Date given) / / age _____ **MENOMUNE** (Date given) / / age _____
Month Day Year Month Day Year
 MENACTRA (Date given) / / age _____ **OTHER** (Date given) / / age _____
Month Day Year Month Day Year
 BOOSTER TYPE _____ (Date given) / /
Month Day Year

Declined Meningococcal Vaccination _____ Date _____
Student Signature Required

Printed Name _____ Date _____

Parental/Legal Guardian Signature _____ Date _____
Required for students under the age of 18

- 4. **TUBERCULOSIS SCREENING** Any student who has resided outside of the U.S. within the last five years, in a country where tuberculosis is endemic is **REQUIRED** to be screened upon arrival to Clemson, or provide proof of screening performed in the U.S. within the past 12 months. **TB screening performed outside of the U.S. will not be accepted.** Residents of the following countries are exempt: Canada, Jamaica, Saint Kitts, Nevis, Saint Lucia, USA, Virgin Islands, Austria, Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, New Zealand.

NAME: _____ Date of Birth: ____/____/____ CUID: _____
Month Day Year

- T-SPOT (Date given) ____/____/____ (Result) _____ (attach copy of result)
Month Day Year
- Tuberculin Skin Test (Date given) ____/____/____ (Date read) ____/____/____ (Result) _____ mm
Month Day Year Month Day Year
- *Chest x-ray (Date given) ____/____/____ (Date read) ____/____/____ (Result) _____
(*Required for positive TB test) Month Day Year Month Day Year

C. RECOMMENDED IMMUNIZATIONS:

1. **HUMAN PAPILLOMAVIRUS (HPV)** Series of three vaccines (either bivalent or quadrivalent) recommended for females age 11-26 years; series of three vaccines (quadrivalent) recommended for males 9-26 years.

HPV Type GARDASIL (HPV4 quadrivalent) CERVARIX (HPV2 bivalent)

(Date given) ____/____/____ (Date given) ____/____/____ (Date given) ____/____/____
Month Day Year Month Day Year Month Day Year

2. **HEPATITIS B** Series of 3 vaccines, or positive titer (attach copy of titer results) ** May be combined with Hepatitis A

HEP B (Date given) ____/____/____ (Date given) ____/____/____ (Date given) ____/____/____
Month Day Year Month Day Year Month Day Year

HEP A-B (Date given) ____/____/____ (Date given) ____/____/____ (Date given) ____/____/____
**Combined Month Day Year Month Day Year Month Day Year

Positive laboratory/serologic evidence of immunity or prior infection may be substituted (attach copy)

3. **HEPATITIS A** Series of 2 vaccines **May be combined with Hepatitis B

HEP A (Date given) ____/____/____ (Date given) ____/____/____
Month Day Year Month Day Year

4. **VARICELLA** Series of 2 doses, given at least one month apart; Documented clinical history of chicken pox; or a positive Varicella titer (attach copy)

VARICELLA (Date given) ____/____/____ (Date given) ____/____/____
Month Day Year Month Day Year

D. HEALTH CARE PROVIDER SIGNATURE OR STAMP REQUIRED*

Name: _____ Date: ____/____/____
(Please Print) Month Day Year

Address: _____
(Street/PO Box) (City) (State)

(Zip code) Phone: (_____) _____
(Area code)

E. EXEMPTIONS

This student is exempt from the following immunizations on grounds of permanent medical contraindication (attach documentation)

MMR Tdap

This student is exempt from the following immunizations until ____/____/____, due to _____ (attach documentation)

MMR Tdap

*SIGNATURE _____ Date: ____/____/____
(Required of health care provider) Month Day Year

After completion of this form return to:
REDFERN HEALTH CENTER RM. 61, Box 344054 CLEMSON UNIVERSITY, CLEMSON, SC 29634-4054 OR FAX TO (864)-656-0760

MEDICAL HISTORY QUESTIONNAIRE

Redfern Health Center

Clemson University

Name (Last, First, M.I.):

M F

DOB:

Social Security #:

CUID:

CU status:

Student

Spouse

Worker's Comp

Visitor on Campus

Exchange Visitor

PERSONAL MEDICAL HISTORY

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> HEADACHES/MIGRAINES	<input type="checkbox"/> NEUROLOGICAL DISORDER
<input type="checkbox"/> ALCOHOL/DRUG USE	<input type="checkbox"/> HEARING DISABILITIES	<input type="checkbox"/> PROLONGED IMMUNOSUPPRESSIVE/ CORTICOSTEROID TREATMENT
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> HEPATITIS B - <input type="checkbox"/> CARRIER	<input type="checkbox"/> PSYCHOLOGICAL/EMOTIONAL CONCERNS
<input type="checkbox"/> CHICKEN POX	<input type="checkbox"/> HEPATITIS C	<input type="checkbox"/> SEIZURES
<input type="checkbox"/> CHRONIC FATIGUE	<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> SKIN DISORDERS
<input type="checkbox"/> DIABETES	<input type="checkbox"/> HIGH CHOLESTEROL	<input type="checkbox"/> SMOKING/TOBACCO USE
<input type="checkbox"/> EATING DISORDERS	<input type="checkbox"/> HIV POSITIVE	<input type="checkbox"/> THYROID DISORDER
<input type="checkbox"/> EYE DISEASE	<input type="checkbox"/> KIDNEY DISEASE	<input type="checkbox"/> MALARIA
<input type="checkbox"/> HEAD INJURY WITH UNCONSCIOUSNESS	<input type="checkbox"/> MONONUCLEOSIS	<input type="checkbox"/> VISION/CORRECTIVE LENSES

Significant Illnesses:

Surgeries:

Year:

FAMILY MEDICAL HISTORY

<input type="checkbox"/> ALCOHOL/DRUG PROBLEM	<input type="checkbox"/> DIABETES	<input type="checkbox"/> HIGH BLOOD PRESSURE
<input type="checkbox"/> ASTHMA/HAY FEVER	<input type="checkbox"/> HEART DISEASE/STROKE	<input type="checkbox"/> HIGH CHOLESTEROL
<input type="checkbox"/> CANCER	<input type="checkbox"/> HEREDITARY DISEASE	<input type="checkbox"/> MIGRAINE HEADACHES
<input type="checkbox"/> OTHER SIGNIFICANT ILLNESSES (LIST)		

List Any Other Medical Problems:

ALLERGIES (DRUGS AND OTHER SEVERE ADVERSE REACTIONS)

<input type="checkbox"/> NO KNOWN DRUG ALLERGIES	<input type="checkbox"/> PENICILLIN	<input type="checkbox"/> LATEX
<input type="checkbox"/> ACETAMINOPHEN	<input type="checkbox"/> SULFA	<input type="checkbox"/> X-RAY CONTRAST
<input type="checkbox"/> ASPIRIN	<input type="checkbox"/> FOOD (LIST BELOW)	<input type="checkbox"/> OTHER (SPECIFY BELOW)
<input type="checkbox"/> LIDOCAINE/XYLOCAINE	<input type="checkbox"/> INSECT/BEE STING	

List Any Other Allergies:

Are you currently taking any medications?

YES

NO

(IF SO, PLEASE LIST BELOW)

Signature of Patient

Date



INFORMATION ABOUT MENINGOCOCCAL DISEASE AND HEPATITIS B

South Carolina law requires all public institutions to inform entering college students about the risks of meningococcal disease and Hepatitis B. Effective April 1, 2011, Clemson University requires the meningococcal conjugate vaccine (Menactra, Menveo) after the 16th birthday for all entering students age 21 or younger. If the initial dose was given before the 16th birthday, a booster is required. Students must present proof of vaccination, or may sign a waiver declining the meningitis vaccination. All other college students who wish to reduce their risk of infection may choose to be vaccinated. The Hepatitis B vaccine is not required but is highly recommended. The meningococcal and Hepatitis B vaccines are available at Redfern Health Center.

Meningococcal Disease

Meningococcal disease is contagious and progresses very rapidly. The bacteria are spread person-to-person through the air by respiratory droplets (e.g., coughing, sneezing). The bacteria also can be transmitted through direct contact with an infected person, such as kissing. If not treated early, meningitis can lead to death or permanent disabilities. One in five of those who survive will suffer from long-term side effects, such as brain damage, hearing loss, seizures, or limb amputation.

Meningococcal disease can affect people at any age. The rate of infection is highest in infancy, with the second peak in adolescence. Annually about 1,000 cases of invasive meningococcal disease occur in the US, with 20% of cases occurring among adolescents and young adults, 14-24. Due to lifestyle factors, such as crowded living situations, bar patronage, active or passive smoking, irregular sleep patterns, and sharing of personal items, college students living in residence halls are more likely to acquire meningococcal disease than the general college population.

In persons 15 to 24 years of age, 70 to 80 percent of cases are caused by potentially vaccine-preventable strains. The Centers for Disease Control and Prevention and the American College Health Association recommend the conjugate meningitis vaccine for all college first-year students living in residence halls to protect against four of the five most common strains (or types) of *N. meningitidis* (A, C, Y, and W-135). There is currently no licensed vaccine that protects against serogroup B in the U.S.

Hepatitis B

Hepatitis B is a contagious liver disease that results from infection with the Hepatitis B virus. When first infected, a person can develop an "acute" infection, which can range in severity from a very mild illness with few or no symptoms to a serious condition requiring hospitalization. Some people are able to fight the infection and clear the virus. For others, the infection remains and leads to a chronic or lifelong illness. Over time, the infection can cause serious health problems including liver damage, cirrhosis, liver failure, and liver cancer. Every year, approximately 3,000 people in the United States and more than 600,000 people worldwide die from Hepatitis B-related liver disease.

In the United States, Hepatitis B is most commonly spread through sexual contact. The Hepatitis B virus is 50–100 times more infectious than HIV and can be passed through the exchange of body fluids, such as semen, vaginal fluids, and blood. According to the Centers for Disease Control and Prevention, the best way to prevent Hepatitis B is by getting vaccinated. For adults, the Hepatitis B vaccine is given as a series of 3 shots over a period of 6 months. The entire series is needed for long-term protection.

Retrieved from:

http://www.acha.org/projects_programs/meningitis/disease_info.cfm

http://www.acha.org/projects_programs/meningitis/nr_cdc.cfm

<http://www.cdc.gov/hepatitis/HBV/PDFs/HepBGeneralFactSheet.pdf>

<http://www.cdc.gov/vaccines/vpd-vac/mening/vac-mening-fs.htm>