



A. TO BE COMPLETED BY THE STUDENT:

Name _____
Last Name First Name Middle CUID #

Address _____
Street/POBox SSN

_____ City State Zip Code Date of Birth

Phone _____ Email _____@clemsn.edu

First term of Enrollment: Fall /Spring /Summer _____year

Student Signature _____ Date _____

B. REQUIRED IMMUNIZATIONS: MUST BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER:

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

2. **TUBERCULOSIS SCREENING INTERNATIONAL STUDENTS OR RESIDENTS**
Any student who has resided in a *country identified by the U.S. Centers for Disease Control and Prevention (or) American College Health Association, where tuberculosis is endemic is required to be screened upon arrival to Clemson.
TB screening will not be accepted from outside the U.S.

Tuberculin Skin Test: (Date given) _____/_____/_____
Month Day Year (Date read) _____/_____/_____
Month Day Year (Result) _____mm
Chest x-ray: (Date given) _____/_____/_____
(required for positive TB test) Month Day Year (Date read) _____/_____/_____
Month Day Year (Result) _____

*Countries of high risk are identified on our Web site www.clemson.edu/redfern

C. RECOMMENDED IMMUNIZATIONS:

1. **MENINGOCOCCAL VACCINE: MENACTRA** _____ (Date given) _____/_____/_____
Month Day Year
MENOMUNE _____ (Date given) _____/_____/_____
Month Day Year



REDFERN HEALTH CENTER
Division of Student Affairs
Box 344054 Clemson, SC 29634-4054
864.656.2234 FA X 864.656.0760 www.clemson.edu/redfern

2. TETANUS- DIPHTHERIA –PERTUSSIS: (Primary series and booster with Td or Tdap in the last ten years)

Booster: Tdap (preferred) with at least 5 years since last dose of TD (Date given) ____/____/____
Month Day Year

Td within the last ten years (Date given) ____/____/____
Month Day Year

3. QUADRIVALENT HUMAN PAPILOMAVIRUS VACCINE (HPV): Series of three vaccines for females age 11-26

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

4. HEPATITIS B: Series of 3 vaccines, or positive titer (attach copy 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

Laboratory/serologic evidence of immunity or prior infection (attach copy) (Date) ____/____/____
Month Day Year

5. HEPATITIS A: Series of 2 vaccines

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

6. VARICELLA: Clinical history of chicken pox, a positive Varicella titer (attach copy), or 2 doses of vaccine given at least one month apart

(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 above immunization on grounds of permanent medical
contraindication. (attach documentation)

_____ This student is exempt from the above immunizations until ____/____/____, due to _____
Month Day Year

***SIGNATURE:** _____
(Required of health care provider)

**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**