IMMUNIZATION FORM

Last Name | First Name | Date of Birth | XID

REQUIRED IMMUNIZATIONS

VACCINE	DATE MM/DD/YYYY	DATE MM/DD/YYYY	DATE OF POSITIVE LAB/SEROLOGIC EVIDENCE	
MMR (Required if born after 1956 or positive titer)	12 Months or Older / /	minimum 1 month after 1st dose / /		
Measles	/ /	/ /	/ /	☐ Copy of Report Attached
Mumps	/ /	/ /	/ /	☐ Copy of Report Attached
Rubella	/ /	/ /	/ /	☐ Copy of Report Attached
Tdap (Required for ages 64 and younger)	☐ Adacel ☐ Boostrix / /			
Meningococcal (Required if 21 or younger or waiver)	☐ Menactra ☐ Menveo / /	Booster required if given before age 16 / /	Booster Type: ☐ Menactra ☐ Menveo	

☐ I have read and understand the risk of the Meningococcal disease and I am declining to receive the vaccine.

Declined Meningococcal Vaccination _____ **Date** _____

Student Signature Required

Parental/Legal Guardian Signature _____ **Date** _____

Required for students under the age of 18

RECOMMENDED IMMUNIZATIONS

VACCINE	DATE MM/DD/YYYY	DATE MM/DD/YYYY	DATE MM/DD/YYYY	DATE OF POSITIVE LAB/SEROLOGIC EVIDENCE	
HEPATITIS A	/ /	/ /	/ /	/ /	☐ Copy of Report Attached
HEPATITIS B	/ /	/ /	/ /	/ /	☐ Copy of Report Attached
HEP A-B	/ /	/ /	/ /		
VARICELLA	/ /	/ /		/ /	☐ Copy of Report Attached
HPV	/ /	/ /	/ /	Series Type: ☐ GARDASIL ☐ CERVARIX ☐ 9-VALENT	

HEALTH CARE PROVIDER SIGNATURE OR STAMP REQUIRED

Name: _____ **Signature:** _____

Address: _____ **Phone:** _____

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Box 344054, Clemson, SC 29634-4054
P: 864-656-2233 F: 864-656-0760
DIVISION OF STUDENT AFFAIRS

MEDICAL HISTORY QUESTIONNAIRE

Name *(Last, First, M.I.):*				M □ F □	**DOB:**
XID:					
CU status:	□ Student	□ Spouse	□ Worker's Comp	□ Visitor on Campus	□ Exchange Visitor

PERSONAL MEDICAL HISTORY

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

Significant Illnesses:

Surgeries: **Year:**

FAMILY MEDICAL HISTORY

□ **ALCOHOL/DRUG PROBLEM**	□ **DIABETES**	□ **HIGH BLOOD PRESSURE**
□ **ASTHMA/HAY FEVER**	□ **HEART DISEASE/STROKE**	□ **HIGH CHOLESTEROL**
□ **CANCER**	□ **HEREDITARY DISEASE**	□ **MIGRAINE HEADACHES**
□ **OTHER SIGNIFICANT ILLNESSES (LIST)**		

List Any Other Medical Problems:

ALLERGIES (DRUGS AND OTHER SEVERE ADVERSE REACTIONS)

□ **NO KNOWN DRUG ALLERGIES**	□ **PENICILLIN**	□ **LATEX**
□ **ACETAMINOPHEN**	□ **SULFA**	□ **X-RAY CONTRAST**
□ **ASPIRIN**	□ **FOOD (LIST BELOW)**	□ **OTHER (SPECIFY BELOW)**
□ **LIDOCAINE/XYLOCAINE**	□ **INSECT/BEE STING**	

List Any Other Allergies:

Are you currently taking any medications? □ **YES** □ **NO** **(IF SO, PLEASE LIST BELOW)**

Signature of Patient/Guardian

Date

Print Name of Patient/Guardian

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