College of Charleston  
Student Health Services Health Form  
181 Calhoun Street, Charleston, SC 29424  
Phone 843-953-5520 Fax 843-953-6377  

Immunization Record

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Date of Birth</th>
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On the recommendation of the American College Health Association and the South Carolina Department of Public Health the following immunizations are required for all undergraduate, graduate, transfer and part-time students. The 2 MMR requirement does not apply to those students born before 1957. A copy of an official immunization record may be attached in place of a health provider’s signature. Please visit our website at [http://studenthealth.cofc.edu](http://studenthealth.cofc.edu) for more detailed information regarding required and recommended immunizations and to access a waiver form. Some recommended vaccines are for certain at-risk groups.

### Required Immunizations
To be completed and signed by your health care provider

#### A. MMR (Measles, Mumps, Rubella)
Two doses at least 28 days apart for students born after 1956

1. Dose One given at first birthday or later
   Date ____________

2. Dose Two given 28 days after first dose or later
   Date ____________

#### B. Quadrivalent Meningitis Vaccine or Signed Waiver
- Name of Vaccine ____________
- Date ____________
- Booster Date ____________

*Meningitis Serogroup B vaccine not required*

### Recommended Immunizations

#### A. Tetanus
Circle one
- DT
- Td
- DTP
- T-DAP

Given within the last ten years
Date ____________

#### B. Hepatitis B
(Series of 3 vaccines)
Dates
- #1 ____________
- #2 ____________
- #3 ____________

#### C. Hepatitis A
(Series of 2 vaccines)
Dates
- #1 ____________
- #2 ____________

#### D. Human Papillomavirus (HPV)
(Series of 3 vaccines)
Dates
- #1 ____________
- #2 ____________
- #3 ____________

#### E. Varicella (Chicken Pox)
(Series of 2 vaccines)
Dates
- #1 ____________
- #2 ____________

#### F. Polio
Circle # of doses received, minimum three
1 2 3 4
Date of last dose ____________

### Optional Travel-Related Immunizations

#### A. Typhoid
Oral/Injectable ____________
Date ____________

#### B. Yellow Fever
Date ____________

#### C. Polio Booster
(Adult Dose)
Date ____________

#### D. Other Vaccine(s)
__________________________
Date ____________
__________________________
Date ____________

Health Care Provider Name/Signature/Stamp ________________________________
Date ____________

Address ______________________________________________________________