

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

**Immunization Record**

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Last Name	First Name	MI	Date of Birth
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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> for more detailed information regarding required and recommended immunizations and to access a waiver form. Some recommended vaccines are for certain at-risk groups.

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

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**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 _____

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**B. Quadrivalent Meningitis Vaccine or Signed Waiver** Name of Vaccine \_\_\_\_\_ Date \_\_\_\_\_ Booster Date \_\_\_\_\_  
***Meningitis Serogroup B vaccine not required***

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**C. Tetanus** Circle one DT Td DTP T-DAP Given within the last ten years Date \_\_\_\_\_

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**Recommended Immunizations**

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**A. Hepatitis B** (Series of 3 vaccines) Dates #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

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**B. Hepatitis A** (Series of 2 vaccines) Dates #1 \_\_\_\_\_ #2 \_\_\_\_\_

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**C. Human Papillomavirus (HPV)** (Series of 3 vaccines) Dates #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

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**D. Varicella (Chicken Pox)** (Series of 2 vaccines) Dates #1 \_\_\_\_\_ #2 \_\_\_\_\_

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**E. Polio** Circle # of doses received, minimum three 1 2 3 4 Date of last dose \_\_\_\_\_

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**Optional Travel-Related Immunizations**

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**A. Typhoid** Oral/Injectable \_\_\_\_\_ Date \_\_\_\_\_

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**B. Yellow Fever** Date \_\_\_\_\_

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**C. Polio Booster** (Adult Dose) Date \_\_\_\_\_

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**D. Other Vaccine(s)** \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_

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Health Care Provider Name/Signature/Stamp \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_