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

Immunization Record

Last Name First Name MI Date of Birth

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.

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

C. Tetanus, Diphtheria and Pertussis (Tdap) Given within the last ten years Date____________

Recommended Immunizations

A. Hepatitis B (Series of 3 vaccines) Dates #1 ____________ #2______________#3_______________

B. Hepatitis A (Series of 2 vaccines) Dates #1____________ #2_______________

C. Human Papillomavirus (HPV) (Series of 3 vaccines) Dates #1 __________ #2___________ #3_____________

D. Varicella (Chicken Pox) (Series of 2 vaccines) Dates #1_____________ #2_______________

E. 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____