STUDENT HEALTH SERVICES

Instructions for completing the IMMUNIZATION / TB PRESCREENING FORM

coastal.edu/health

Dear Student ~ Welcome to CCU!

Coastal Carolina University requires a complete immunization record for all students, therefore, please complete and return the attached immunization form. Be certain to include your full name, date of birth, and CCU ID number or Social Security Number. Completed forms must be returned prior to May 1 for Summer semester enrollment; August 1 for Fall semester enrollment; or December 1 for Spring semester enrollment. ***Students not in compliance with immunization requirements will not be allowed to complete registration for the next semester.***

Mail completed form to:
Coastal Carolina University
Student Health Services
P.O. Box 261954
Conway, SC 29528-6054

OR **Fax to: 843-349-6546**

Guidelines for Completing Immunization Records
According to University policy, the immunization requirements must be met and on file at Student Health Services. In order to avoid excessive wait times, please have all of your immunization requirements completed and forms submitted prior to your orientation date. If you are unable to obtain your records, all required immunizations are available to you at Student Health Services for a nominal fee.

Acceptable immunizations records
- Personal shot records verified by a healthcare provider signature or stamp
- Personal shot records with a clinic or health department stamp
- Military Records or World Health Organization (WHO) documents
- Previous college or university records that are verified (Please note that your immunization records do not transfer automatically; you must request a copy from your school.)
- Positive laboratory test as confirmation of immunity

Be certain that your name, date of birth, and CCU ID number or Social Security number appear on each sheet and that all forms are mailed together. Complete these forms in black ink. The dates of vaccine administration **must** include the month, day and year. All records must be in **English**. Please keep a copy for your own personal records.

SECTION A: Personal Information
To be completed by the student. Please include all the demographic information requested including name, address, date of birth, identifying information and **your signature**.

SECTION B: Required Immunizations / Tuberculosis Prescreening
Please have your physician or health department clinician complete your immunization record and update any needed immunizations that are required in Section B. ***This form must be signed or stamped by a health care provider.*** A Tuberculosis prescreening test is **required** for any student who has resided in a country within the last five years that has been identified as "high risk" for tuberculosis. Please refer to **http://apps.who.int/ghodata** for a list of high risk countries. **Students arriving from outside the U.S. are required to obtain this screening upon arrival at CCU.** ***TB screenings performed outside of the U.S. will not be accepted.***

SECTION C: Recommended Immunizations
Certain academic departments and programs may require immunizations in addition to the minimum requirements for enrollment. Please consult with your academic department for specifics on any additional requirements. Student Health Services, based on recommendations from the Centers for Disease Control and Prevention (CDC) and the American College Health Association (ACHA), recommends receiving the immunizations listed in Section C. You may elect to receive these immunizations from your private physician or health department prior to arriving at the University.

SECTION D: Immunization Exemptions
Immunization requirement waivers may be obtained for the following reasons: students born before 1957; students registered only in off campus courses (i.e., teacher cadets, distance learning); students registered in Osher Lifelong Learning Institute courses; University faculty/staff that are enrolled students; or religious and medical exemptions. Please attach additional documentation for the medical or religious need for an exemption to any immunization requirement. Go to **coastal.edu/health/forms.html**, print the appropriate exemption form and follow the instructions on the form.

SECTION E: Healthcare Provider Signature or Stamp
Completion of this section by your healthcare provider is required, including a signature or stamp.

COASTAL CAROLINA UNIVERSITY • STUDENT HEALTH SERVICES
IMMUNIZATION/TB PRESCREENING FORM

A. Last name (print) _____ **First** _____ **Middle** _____

Social Security number / CCU ID number _____ Date of birth _____

Permanent address _____

City _____ State/Country _____ Zip code _____

Telephones: Home (_____) _____ Cell (_____) _____

Email _____

First Term of Enrollment (Month/Year) _____

This information is true and accurate to the best of my knowledge.

Student's signature _____ Date _____

B. Required Immunizations Sections B, C, D must be completed and signed by your Health Care Provider

1. Measles/Mumps/Rubella (MMR) (2 doses required)

1. Dose #1: (Date) _____ /_____ /_____ (1st dose after 1st birthday; 2nd dose must be 28 days after first dose)
Month Day Year

2. Dose #2: (Date) _____ /_____ /_____ OR
Month Day Year

Rubeola (Measles) (Date) _____ /_____ /_____ Re-immunized (Date) _____ /_____ /_____ **OR** Titer (Date) _____ /_____ /_____
Month Day Year Month Day Year Month Day Year

OR Illness (Date) _____ /_____ /_____
Month Day Year

Rubella (German measles) (Date) _____ /_____ /_____ Re-immunized (Date) _____ /_____ /_____
Month Day Year Month Day Year

Mumps (Date) _____ /_____ /_____ Re-immunized (Date) _____ /_____ /_____ **OR** Titer (Date) _____ /_____ /_____
Month Day Year Month Day Year Month Day Year

OR Illness (Date) _____ /_____ /_____
Month Day Year

2. Tetanus, Diphtheria, and Acellular Pertussis(TDAP)
Single dose within the last 10 years required for all students age 64 years or younger.

DTAP, DTP, DT, or TD (Date given) _____ /_____ /_____ **Adacel** (Date given) _____ /_____ /_____
Month Day Year Month Day Year

Boostrix (Date given) _____ /_____ /_____
Month Day Year

3. Meningococcal Vaccine: Proof of a conjugate meningococcal vaccine (e.g. Menactra, Menomune) or a signed waiver declining the vaccine is required of all incoming students under 25 years of age living in residence halls. If declining this vaccination, a parent/legal guardian's signature is required for students under the age of 18. Revaccination is recommended every five years.

Meningococcal Vaccine (Date) _____ /_____ /_____ Menactra (Date) _____ /_____ /_____

Menomune (Date) _____ /_____ /_____ Menveo (Date) _____ /_____ /_____

☐ **Declined Meningococcal Vaccination** _____ Date _____
(Signature Required)

PRINT Name _____ Date _____

Parent/Legal Guardian Signature _____ Date _____
(Parent/Legal guardian signature required if student is under the age of 18)

Name of student: *(print)* _____ **SSN *or* CCU ID #** _____

4. Tuberculosis(TB) Screening Questionnaire (to be completed by incoming students)

Please answer the following questions:

Have you ever had close contact with person(s) known or suspected to have active TB disease? ☐ Yes ☐ No

Were you born in one of the countries listed with a high incidence of active TB disease? ☐ Yes ☐ No
Please refer to **cdc.gov** or **http://apps.who.int/ghodata** for a complete list of high risk countries.

Please list the country you are from _____

Have you had frequent or prolonged visits to one or more of the high risk countries listed with a high prevalence of TB disease? Please name high risk country _____ ☐ Yes ☐ No

Have you been a resident and/or employee of high-risk congregate setting(s) (i.e., correctional facilities, long-term care facility, and/or homeless shelter)? ☐ Yes ☐ No

Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease? ☐ Yes ☐ No

Have you ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease – medically underserved, low-income, or abuse of drugs or alcohol? ☐ Yes ☐ No

- ► **If the answer is YES to any of the above questions**, please download and complete the TB Risk Assessment form at **coastal.edu/health/form/html**. This form must be completed by your health care provider prior to the beginning of the semester.
- ► **If the answer to all of the above questions is NO**, no further testing or further action is required.

C. Recommended Immunizations

1. **Hepatitis A** (2 Doses) Dose #1: _____ (Month) /_____ (Day) /_____ (Year) Dose #2: _____ (Month) /_____ (Day) /_____ (Year)

2. **Hepatitis B** (3 Doses) Dose #1: _____ (Month) /_____ (Day) /_____ (Year) Dose #2: _____ (Month) /_____ (Day) /_____ (Year) Dose #3: _____ (Month) /_____ (Day) /_____ (Year)

3. **Varicella (chicken pox)** (immunization or disease) (2 Doses)

   History of Disease: ☐ Yes ☐ No Documented by Medical Provider

   Dose #1: _____ (Month) /_____ (Day) /_____ (Year) Dose #2: _____ (Month) /_____ (Day) /_____ (Year)

4. Quadrivalent Human Papillomavirus (HPV) (3 Doses)

   Dose #1: _____ (Month) /_____ (Day) /_____ (Year) Dose #2: _____ (Month) /_____ (Day) /_____ (Year) Dose #3: _____ (Month) /_____ (Day) /_____ (Year)

D. Exemptions

Students may request an exemption from the University's Immunization requirements due to the following reasons. Please check appropriate box and attach documentation if applicable.

☐ Born Before 1957 ☐ Religious Exemption ☐ Medical Exemption

☐ University Faculty and Staff ☐ Students registered only in off campus courses

E. Health Care Provider Signature or Stamp Required

Name (Please Print)_____ Date_____

Address _____

City _____ State _____ Zip code _____

Telephone (_____) _____ Fax (_____) _____

Signature/Stamp _____ Date _____