MUSC
Medical University
of South Carolina

Student Health Services
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MUSC Student Pre-Matriculation Requirements

Instructions for Completion of Form

All MUSC students, including full-time, part-time, distance, current employees, or returning former students, are required to submit the following information. The Mandatory Immunization Requirements Form and supporting documentation must be completed and received by Student Health Services before students will be allowed to attend classes. Maintaining these high standards is done to protect the safety of the students, staff, and patients.

1. **Measles, Mumps, Rubella –** proof of age-appropriate immunization **OR** immune antibody titers *.
Immunization requirements can be met by providing documentation of 2 MMR vaccines received on/after age of 12 months, and both after 12/31/1967. Students born before 12/31/1956 can submit documentation of one MMR dose given after 12/31/1967. **OR**
Immune Antibody Titers - Copy of lab report demonstrating immune antibody titers (IgG) to Measles, Mumps, and Rubella. Lab report should be quantitative and/or specify if test results are in immune range.

2. **Varicella (Chicken Pox) Immunity**

- Documentation of two Varicella vaccines
  OR
- Copy of lab report demonstrating immune antibody titers (IgG)* to Varicella. Lab report should be quantitative and/or specify if test results are in immune range.

3. **Tetanus-diphtheria-acellular pertussis (Tdap) –** students are to have completed the childhood DPT series within current CDC guidelines **and** provide documentation of having received an adult **Tdap** booster on or after 5/3/2005. Once adult Tdap booster has been received, students may resume regular Td boosters every 10 years. Students with a documented allergic reaction to the pertussis vaccine need to provide a letter from their medical provider detailing the nature of their reaction and the contraindication to receiving the vaccine.

4. **Meningitis Vaccine** – documentation of vaccine or signed waiver.

5. **Hepatitis B Vaccination –** is required for students who may have exposure to blood or human body fluids during their academic coursework. Unvaccinated students should initiate the hepatitis B vaccine series prior to or during their first semester at MUSC. Previously immunized students must provide proof of the primary hepatitis B series (3 vaccines) **AND** a Quantitative Hepatitis B surface Antibody titer (preferably drawn 4-8 weeks after the final dose). Lab report should specify if test results are in the desired immune range (≥ 10 mIU/mL). If the hepatitis B titer is non-immune (negative or equivocal) immediately after completion of the primary vaccine series, then complete a second hepatitis B series followed by a repeat titer. Many who completed their primary hepatitis B series during infancy will have a negative hepatitis antibody titer when first tested as an adult, often due to waning antibody levels over time. In this population, it is acceptable to receive a fourth hepatitis B vaccine "booster" followed by a hepatitis antibody titer 4-6 weeks later. If this hepatitis B titer is immune (≥ 10 mIU/mL), then no further hepatitis vaccines are needed. If the titer is negative, then the second vaccine series should be completed, followed by a hepatitis B antibody titer. If the hepatitis B antibody titer is negative after 2 completed hepatitis B vaccine series, then testing for chronic hepatitis B infection is required (Hepatitis B surface Antigen and Hepatitis B core Antibody).

* The **College of Nursing requires ALL Accelerated BSN students** to have MMR and Varicella Titers - regardless of immunization history. This is to satisfy the requirements of some of the affiliated clinical sites. It is still important to submit immunization documentation if available.

6. TB Screening - TB screening tests (TB Skin Test or Blood Assay) **required** of all students regardless of prior BCG vaccination (and complete appropriate section A, B, or C on form). Do not have a TB skin test placed within 28 days of receiving a live vaccine (MMR or Varicella) – this can give a false negative result. Previous history of previous positive TB skin testing (≥ 10 mm induration) or (+) TB Blood Assay **must** be accompanied by documentation of the evaluation and treatment of this condition.

A. Negative Baseline Tuberculosis Screening Tests – persons with negative TB testing need one of the following:

- Two (2) tuberculosis skin tests (Mantoux 5 TU Tuberculin Skin Tests) administered 1 – 3 weeks apart, and both within 3 months of enrollment.
- History of recent TB Skin Testing – persons who have had previous TB skin testing within 12 months of enrollment can submit documentation of this test, along with an additional TB skin test given within 3 months of enrollment.
- Blood Assay for Tuberculosis (Interferon Gamma Release Assay/IGRA) within 3 months of enrollment: *QuantiFERON® TB Gold* or *T-SPOT*

B. Positive TB Testing/Latent Tuberculosis Infection – **new or previous (+) TB skin test or Blood Assay with negative Chest X-ray**. The majority of healthy persons infected with tuberculosis are able to contain the initial infection, though viable TB microorganisms will remain present in their lungs for the rest of their life (latent tuberculosis infection or LTBI). Persons with LTBI are asymptomatic, not contagious, and will have a normal chest x-ray. Their only evidence of infection will be a positive TB skin test and/or blood assay (BAMT). Therefore, **a negative chest x-ray does not rule out the presence of TB or the need for treatment**. About 5-10% will develop active pulmonary tuberculosis at some point in their life, most often during the first few years after infection. Anti-tuberculosis medication decreases the chance of developing active TB infection by up to 90%. Persons with (+) skin tests and/or blood assays for TB **are required** to have been evaluated by the health department to determine their TB status and the need for preventive treatment. Provide:

- Documentation of your TB testing (TB Skin Test or Blood Assay)
- Chest X-ray Report (done after + TB testing) *Foreign-born students with positive TB skin testing who have received the BCG vaccine, should get a Blood Assay for Tuberculosis/ BAMT (*QuantiFERON® TB Gold* or *T-SPOT*) for further evaluation. If BAMT is positive for TB, then a chest x-ray, TB Symptom Survey, and evaluation by the Health Department is required. If BAMT is negative, it may obviate the need for getting a chest x-ray.
- TB Symptom Survey
- Evaluation by the health department +/- the records of your preventive treatment. If LTBI is not treated, provide reason.

C. History of Active Tuberculosis - Required documentation includes:

- Documentation of positive TB test (TB Skin Test or Blood Assay)
- Chest X-ray Report (done after + TB test)
- TB Symptom Survey
- Health Department records of your TB treatment (Medications, Dates of Treatment, etc.).

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MEDICAL UNIVERSITY of SOUTH CAROLINA

Name: _____ Date of Birth: _____ College: _____

INSTRUCTIONS FOR COMPLETION OF IMMUNIZATION FORM

Acceptable Documentation:

- Medical records from the provider that administered the immunizations, state issued records, employee health records and immunizations administered at a college. Previous college health forms are only acceptable for the vaccines they administered. Supporting documentation must be included for every vaccine required.
- Immunization documents must contain the signature or stamp of the providing facility, must be in English, and must be legible.
- All dates must include the month, day, year (mm/dd/yy).
- Copies of the original lab report (with values/indices/reference ranges which indicate if immunity is present) must accompany this form.

NOTE: Computer print-outs of transcribed titer results from a health clinic is not acceptable. Re-vaccination may be required for IgG Antibody titers that are non-immune. In lieu of antibody titers, documentation of age appropriate vaccination (MMR, Varicella) is acceptable proof of immunity.

Unacceptable Documentation:

- Lab reports with ambiguous results - Unacceptable results ("Reactive", "Antibody Detected", "Positive"), unless the reference range on the lab document indicates these results indicate immunity.
- Partial dates – must include month/day/year (mm/dd/yy).
- Parental signatures verifying vaccination.

MEDICAL CONTRAINDICATION TO REQUIRED VACCINES – a written statement from a qualified healthcare provider is required indicating the adverse reaction or medical circumstances for which immunization is not considered safe.

1. MEASLES (Rubeola), MUMPS, RUBELLA (German Measles) IMMUNE IgG Antibody Titers (copy of lab report required) or MMR Vaccines as indicated below.

*Students born **on or after 01/01/1957 : Immune IgG MMR Titers or TWO MMR Vaccines received on or after age of 12 months AND both after 12/31/67**

*Students born **on or before 12/31/1956 : Immune IgG MMR Titers or ONE MMR Vaccine received after 12/31/67**

ANTIBODY TITER	MONTH / DAY / YEAR	TITER RESULTS : Negative / Equivocal / Borderline / Indeterminate Titers require proof of (2) MMR vaccines			
Measles / Rubeola IgG		☐ Immune	☐ Equivocal / Borderline	☐ Negative / Non-Immune	☐ Lab Report Attached
Mumps IgG		☐ Immune	☐ Equivocal / Borderline	☐ Negative / Non-Immune	☐ Lab Report Attached
Rubella IgG		☐ Immune	☐ Equivocal / Borderline	☐ Negative / Non-Immune	☐ Lab Report Attached

MMR VACCINES	MONTH / DAY / YEAR	Verifying Documentation Attached
#1 Measles---Mumps---Rubella		
#2 Measles---Mumps---Rubella		

2. VARICELLA (CHICKEN POX) IMMUNE IgG Antibody Titer (copy of lab report required) OR VACCINATION - 2 Varicella Vaccines (*Varivax*)given 4-8 weeks apart). *Varivax* first available 3/17/95.

ANTIBODY TITER	MONTH / DAY / YEAR	TITER RESULTS : Negative / Equivocal / Borderline / Indeterminate Titer requires vaccination.			
Varicella IgG Titer:		☐ Immune	☐ Equivocal / Borderline	☐ Negative / Non-Immune	☐ Lab Report Attached

VARICELLA VACCINES	MONTH / DAY / YEAR	Verifying Documentation Attached
#1 Varivax		
#2 Varivax		

3. TETANUS/DIPHTHERIA/PERTUSSIS (Tdap): *"Adacel" or "Boostrix"*) first available 5/3/2005.

After a one-time dose of ADULT Tdap , Tetanus/Diphtheria (Td) boosters can be resumed. ONLY Exception for Tdap requirement is documentation of PERTUSSIS ALLERGY from healthcare provider.

TETANUS VACCINES	MONTH / DAY / YEAR	Verifying Documentation Attached
Tetanus/Diphtheria/Pertussis (Tdap)		
Tetanus/Diphtheria (Td)		

4. Meningitis Vaccine Proof of Vaccination OR Signed Waiver	MONTH / DAY / YEAR	☐ Menactra ☐ Menveo ☐ Menomune ☐ Unknown (Attach Documentation of Vaccination) ☐ I do not wish to receive the meningococcal vaccine. I have read the information and completed the on-line form at https://lifenet.musc.edu

5. Hepatitis B Vaccine Series AND Immune Titer: Required for individuals who may have exposure to blood or human body fluids (Patient Care, Lab duties, etc.)

Primary Hepatitis B Vaccine Series	Dose #1 _____/_____/_____ MONTH/ DAY / YEAR	Dose #2 _____/_____/_____ MONTH/ DAY / YEAR	Dose #3 _____/_____/_____ MONTH/ DAY / YEAR	☐ Attach documentation of vaccination
	Hepatitis B Surface IgG Antibody Titer Date_____	☐ Immune Titer _____mIU/mL Titer Result	Non – Immune Titer ☐Equivocal/Borderline ☐ Negative Equivocal or Negative Titers – see Page 1	☐ Lab Report Attached

Secondary Hepatitis B Vaccine Series (If Non-Immune After Primary Series)	Dose #4 _____/_____/_____ MONTH/ DAY / YEAR	Dose #5 _____/_____/_____ MONTH/ DAY / YEAR	Dose #6 _____/_____/_____ MONTH/ DAY / YEAR	☐ Attach documentation of vaccination
	Hepatitis B Surface IgG Antibody Titer Date_____	☐ Immune Titer _____mIU/mL Titer Result	Non – Immune Titer ☐Equivocal/Borderline ☐ Negative Equivocal or Negative Titers – see Page 1	☐ Lab Report Attached

Hepatitis B Vaccine Non-responder (If Hepatitis B Surface Antibody Negative after Primary and Secondary Series)	Date:	Hepatitis B Surface Antigen (If 2nd titer is negative)	(Attach Lab Report)
	Date:	Hepatitis B Core Antibody (If 2nd titer is negative)	(Attach Lab Report)
Chronic Active Hepatitis B	Date:	Hepatitis B Surface Antigen	(Attach Lab Reports)
	Date:	Hepatitis B Viral Load (PCR)	

MUSC
MEDICAL UNIVERSITY of SOUTH CAROLINA

Name: _____ Date of Birth: _____ College: _____

Tuberculosis Screening

All students must complete one of the TB Sections (A, B, or C) below. Results of TB screening tests (TB Skin Test or Blood Assay) **required** of all students regardless of prior BCG vaccination. Do not have a TB skin test placed within 28 days of receiving a live vaccine (MMR or Varicella) – this can give a false negative result. Follow instructions on cover sheet to complete the appropriate section on this form.

SECTION A	**Negative Baseline Tuberculosis Screening**			
	Date Placed	**Date Read**	**Result**	**Documentation**
TB Skin Test #1	____ /____/_____	____ /____/_____	____ mm Induration ☐ Pos ☐ Neg ☐ Equiv	☐ Copy of Report Attached
Skin TB Test #2	____ /____/_____	____ /____/_____	____ mm Induration ☐ Pos ☐ Neg ☐ Equiv	☐ Copy of Report Attached
TB Blood Assay	**Date**		**Result**	
☐ *QuantiFERON® TB Gold* ☐ *T-SPOT*	____ /____/_____		☐ Negative ☐ Indeterminate	☐ Copy of Report Attached

SECTION B	**Positive TB Testing With Negative *Chest X-Ray**			
Positive TB Testing	*Persons born outside the US who have received the BCG vaccine are required to provide documentation of TB screening tests. Those with + TB skin tests should receive a TB Blood Assay (*Quantiferon* or *T-Spot*). If TB Blood Assay is +, then a chest x-ray, TB Symptom Survey, and evaluation by Health Department are required prior to enrollment.			
TB Skin Test (≥ 10 mm) And/Or TB Blood Assay	Date Placed ____ /___ /_____	Date Read ____ /____ /_____	Result ____ mm Induration	☐ Copy of Report Attached
	Test ☐ *QuantiFERON® TB Gold* ☐ *T-SPOT*	Test Date ____ /____ /_____	Results _____	☐ Copy of Report Attached
Chest X-Ray (CXR) (Taken after + TB Test)	Date of CXR ____ /____/_____	CXR Reading: ☐ Normal (No Evidence of TB) ☐ Abnormal		☐ Copy of Report Attached
Health Dept Evaluation?	☐ YES ☐ NO	Date of Evaluation: ____ /____ /_____	Recommendation:	☐ Copy of Report Attached
Prophylactic Treatment For Latent TB?	☐ YES ☐ NO _____ Provide Reason Not Treated	Tx Started: ___ /___ /____ Tx Ended: ___ /___ /____	Medication(s): _____	☐ Copy of Report Attached
TB Symptom Survey	Date Of Survey: ____ /____ /_____	Any "Yes" Responses to Symptoms on TB Survey? ☐ Yes ☐ No		☐ Copy of Survey Attached

Section C	**History of Active Tuberculosis Infection**			
TB Skin Test (≥ 10 mm)	Date Placed ___ /___ /_____	Date Read ____ /____ /_____	Result ____ mm Induration	☐ Copy of Report Attached
TB Blood Assay	**Test** ☐ *QuantiFERON® TB Gold* ☐ *T-SPOT*	Test Date ____ /____ /_____	Results _____	☐ Copy of Report Attached
Chest X-Ray (CXR) (Taken after + TB Test)	Date of CXR ____ /____/_____	CXR Reading: _____		☐ Copy of Report Attached
Report from Health Department Required	Date of Evaluation: ____ /____ /_____		Recommendation:	☐ Copy of Report Attached
TB Treatment	Medication(s):	Tx Started: ____ /____ /_____ Tx Ended: ____ /____ /_____		☐ Copy of Health Dept Report
TB Symptom Survey	Date Of Survey: ____ /____ /_____	Any "Yes" Responses to Symptoms on TB Survey? ☐ Yes ☐ No		☐ Copy of Survey Attached

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MEDICAL UNIVERSITY of SOUTH CAROLINA

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OPTIONAL IMMUNIZATION DOCUMENTATION

Immunization requirements may vary for students doing clinical rotations at institutions outside MUSC or who will be participating in foreign travel (e.g. medical mission trips, etc.). Some will require documentation of childhood vaccine series (Polio, DPT, etc.). Having this documentation available will assist Student Health complete the necessary forms to clear you for these activities. If you anticipate participation in clinical activities outside MUSC and would like to have this information available to Student Health, please provide documentation of these immunizations and complete the following section(s).

Diphtheria/Tetanus/Pertussis – Initial Childhood Series

Diphtheria/Tetanus/Pertussis – Initial Childhood Series
DPT / DTaP / TD (circle one) Date Administered ____ / ____ / ____
DPT / DTaP / TD (circle one) Date Administered ____ / ____ / ____
DPT / DTaP / TD (circle one) Date Administered ____ / ____ / ____
DPT / DTaP / TD (circle one) Date Administered ____ / ____ / ____
DPT / DTaP / TD (circle one) Date Administered ____ / ____ / ____

Polio Series

Polio
OPV / IPV (circle one) Date Administered ____ / ____ / ____
OPV / IPV (circle one) Date Administered ____ / ____ / ____
OPV / IPV (circle one) Date Administered ____ / ____ / ____
OPV / IPV (circle one) Date Administered ____ / ____ / ____
OPV / IPV (circle one) Date Administered ____ / ____ / ____

MUSC
MEDICAL UNIVERSITY of SOUTH CAROLINA

Name: _____ Date of Birth: _____ College: _____

Hepatitis A

	Dose 1	Dose 2
Month/Day/Year Of Vaccine	____ / ____/ ____	____ / ____/ ____
	❒HAVRIX ❒VAQTA	❒HAVRIX ❒VAQTA

Human Papilloma Virus (HPV)

◘ *Cervarix* **(2vHPV)** ◘ *Gardasil* **(4vHPV)** ◘ *Gardasil* **(9vHPV)**

	Dose 1	Dose 2	Dose 3
Month/Day/Year Of Vaccine	____ / ____/ ____	____ / ____/ ____	____ / ____/ ____

Other Vaccines

	Date (mm/dd/yyyy) Partial dates are not accepted
Pneumococcal Vaccine	
Pneumovax 0.5 cc	_____ / _____ / _____
Pneumovax 0.5 cc	_____ / _____ / _____
Other Vaccines	
IPOL (Inactivated Polio Vaccine) 0.5cc Adult Booster	_____ / _____ / _____
Typhoid Oral Vaccine (Ty21a) x 4 capsules	_____ / _____ / _____
Typhim Vi (ViCPS) 0.5cc	_____ / _____ / _____
Yellow Fever Vaccine (YF-VAX) 0.5cc	_____ / _____ / _____
Miscellaneous Vaccines	Please attach any additional vaccines with vaccine/dates/verification information.

*Upload your completed form and documentation to Lifenet at https://lifenet.musc.edu by selecting "IMMUNIZATIONS" from the center menu. You will also need to enter the dates of all of your immunizations, titers, and TB tests here as well.

*Once you have entered your information and uploaded the form and documentation, a member of the Student Health staff will review your immunizations for compliance and you will be notified through Lifenet messaging if your records are complete or if you have any deficiencies.

* If you still have questions after reading the directions and the pre-matriculation form carefully, please send an email to shsimmunizations@musc.edu as we are currently unable to answer immunization questions by phone at this time.