MUSC Health
MEDICAL UNIVERSITY of SOUTH CAROLINA

IMMUNIZATION INFORMATION

Candidate Name: _____ DOB:___/___/___ Date:_____

College/Program: _____ Start Date: ___/___/___ End Date: ___/___/___

Contact Person:_____ Contact Number:_____

Will you have animal contact? Yes ____ No ____ (if yes, additional paperwork is required)

This must be completed and signed by a health representative or your Health Care Provider

We may request to see original documentation, but please only submit this form to your MUSC Contact.

I. Required of all applicants.

1. Tuberculosis Screening:

- **A quantiferon gold blood assay (QTFG) or TSPOT within 90 days of placement will be accepted in place of a two-step TB Test. Result Date:___/___/___ Results: _____**

OR

- **TB (PPD) TEST:** Must be within three months prior to MUSC placement.
  Placed:___/___/___ Read:___/___/___ Results: Induration _____mm Erythema _____mm
- **Second Step TB (PPD) TEST:** Must be within three months prior to MUSC placement. Placed:___/___/___ Read:___/___/___ Results: Induration _____mm Erythema _____mm

If you have had a positive TB test, documentation of the past positive and chest x-ray report must be attached.
Date of past positive:___/___/___ Results:_____mm; Date of x-ray:___/___/___ Results:_____

2. VARICELLA (Chicken Pox): History of disease: Date: ___/___/___. If no history, vaccines or titer required. Vaccines: #1 Date:___/___/___ #2 Date:___/___/___ **OR** Titer Date:___/___/___
Results:_____

II. Required if you will have contact with patients, recommended for all others.

RUBEOLA (Red Measles) Vaccine: TWO Live Vaccines after 12/31/67 **or** Titer required. If born before 1957, only one vaccine required.
Vaccines: #1 Date:___/___/___ #2 Date:___/___/___ **OR** Titer Date:___/___/___ Results:_____

RUBELLA (German Measles) Vaccine: Live Vaccine **or** Titer required.
Vaccine: Date:___/___/___ **OR** Titer Date:___/___/___ Results:_____

MUMPS Vaccine: Live Vaccine **or** Titer required.
Vaccine: Date:___/___/___ **OR** Titer Date:___/___/___ Results:_____

III. Recommended if you will have patient contact.

HEPATITIS B Vaccine: Vaccines **and** Titer required.

Vaccines: #1 Date:___/___/___ #2 Date:___/___/___ #3 Date:___/___/___ **AND** Titer Date:___/___/___ Results:_____

TETANUS/Tdap Vaccine: Must be within last ten years. Date:___/___/___

My signature below certifies that the above information is accurate.

Signature of Physician or Student Health Official: _____ Date:_____

(**Self-signature not accepted**.)