

Immunization Information

Welcome to Winthrop University! We are glad you have chosen Winthrop to accomplish your higher education goals.

Proof of immunization or immunity (see Immunization Form) is REQUIRED OF ALL STUDENTS in order to register for classes. Please complete the following Immunization Form. After making a copy for your personal records, return it in person, by mail, or fax to Health and Counseling Services.

Guidelines for Completing Immunization Form

Please send your completed Immunization Form to Health and Counseling Services prior to your orientation session. You may also bring the completed form with you to orientation. Any immunization requirement can be completed at Winthrop University Health Services. **Failure to submit a completed form by the first day of classes will result in a non-refundable \$50 fee. This fee is avoidable.** Please satisfy the immunization requirements prior to your first day of class. Please call 803/323-2206 if you have questions.

Acceptable Records of Your Immunizations

Documentation of immunization means a healthcare provider or Health Department must sign your Immunization Form OR you must attach an official certificate, such as from the military or Health Department. Each page must include your full name and date of birth and all records should be mailed together. The records must be in black ink and the dates of vaccine administration must include the month, day, and year. All records must be in English.

You can use the following resources to obtain your records:

- ✓ **Healthcare provider's office:** These records must be verified by a healthcare provider's stamp and/or signature.
- ✓ **Personal shot records:** These records must be verified by a healthcare provider's stamp and/or signature or by a Health Department stamp.
- ✓ **Local Health Department:** These records must be verified by a healthcare provider's stamp and/or signature or by a Health Department stamp.
- ✓ **High school records:** These may contain some, but not all of your immunization information. Your immunization records do not transfer automatically. You must request a copy from your high school.
- ✓ **Previous college or university:** Your immunization records do not transfer automatically. You must request a copy from your school.
- ✓ **Military records or World Health Organization (WHO) documents.**

Page 1, Complete and sign Page 1. If you are under the age of 18, you will need a signature from a parent or legal guardian authorizing any medical treatment sought at the university.

Page 2, Section 1A – Tuberculosis Screening Questionnaire. Complete and sign the screening questionnaire. Follow instructions, complete TB skin test or Interferon Gamma Release Assay (IGRA) blood test, if indicated.

Page 2, Section 2 – Required Immunizations. Have your healthcare provider or Health Department clinician fill in your immunization record, update any needed immunizations, and sign and/or stamp the form. Please note in Section 2C, you must have meningococcal vaccine or sign the form to decline.

Page 2, Section 3- Recommended Immunizations. See information below.

Health and Counseling Services recommends additional vaccinations as noted on the Immunization Form. You may elect to receive these immunizations from your private healthcare provider or Health Department prior to arriving at the university.

South Carolina Code of Laws, Section 59-101-290

Section 59-101-290. Notification of risk of contracting certain diseases if living on campus.

- (A) A public institution of higher learning shall notify incoming students, or the parent or guardian of an incoming student under the age of eighteen, of the risk of contracting meningococcal disease and Hepatitis B if living in on-campus student housing.
- (B) A public institution of higher learning shall include vaccination against meningococcal disease and Hepatitis B as recommended immunization in health and medical information provided to students or prospective students and parents or guardians.



IMMUNIZATIONS FOR THE COLLEGE POPULATION

Meningitis - More information is available at www.cdc.gov/vaccines/vpd-vac/mening/who-vaccinate.htm

Meningococcal disease is a potentially life threatening bacterial infection that strikes 1,400 - 2,800 Americans each year. The disease causes inflammation of the membranes surrounding the brain, spinal cord and infection in the blood and other tissues. ACHA estimated that 100-125 cases of meningococcal disease occur annually on college campuses, and 5 to 15 students die as a result. The disease is transmitted through the air via droplets of respiratory secretions and by direct contact with persons infected with the disease. Oral contact with shared items such as cigarettes or drinking glasses or through intimate contact such as kissing could put a person at risk for acquiring the infection.

The CDC, ACHA and ACIP recommend Meningitis MCV4 vaccine for all persons 11-18 years old, others at risk and all freshman college students living in residence halls. If vaccine was received prior to age 16, a booster is highly recommended. The South Carolina Commission on Higher Education recommends all freshman and other entering college students under the age of 25 years living in on-campus student housing provide proof of immunization with a conjugate meningococcal vaccine or provide a Meningitis Waiver Form declining the vaccination after reading the risks and hazards of bacterial meningitis.

Meningococcal MCV4 vaccine will protect against four common forms of Nisseria Meningitis (A, C, Y and W-135); **however, no vaccine is guaranteed to protect 100% of individuals.** The fastest rising form of the disease among college students is group C. Side effects of the vaccine may include mild pain and redness at the injection site. Some individuals may have other reactions like headache, fever and chills.

Winthrop University has added meningococcal vaccine to its required immunizations. You may comply with the requirement by showing documentation of the meningitis vaccine and booster, if needed, or completing the signed waiver on the Immunization Form.

Hepatitis B - More information is available at: www.cdc.gov/vaccines/vpd-vac/hepb/default.htm

Hepatitis B is a serious disease of the liver caused by the Hepatitis B virus (HBV). Symptoms of the acute illness caused by HBV may include loss of appetite, diarrhea and vomiting, fatigue, jaundice (yellow skin and/or eyes), pain in joints, muscles and stomach. HBV can also cause a long-term or chronic illness in which the inflammation of the liver leads to liver damage, liver cancer, and death.

HBV is spread through contact with infected blood or body fluids of a person with HBV. It can be acquired through open cuts, wounds, or mucus membranes, by having unprotected sex, by sharing needles, and passed on to a baby during the birth process. Probably one-third of people who are infected with HBV in this country do not know how they got it. **Hepatitis B vaccine can prevent Hepatitis B infection.** It is considered the first anti-cancer vaccine because it can prevent a form of liver cancer.

Since 1991, Hepatitis B vaccine has been included in the schedule of childhood immunizations recommended by the CDC and the Advisory Committee on Immunization Practice (ACIP). Infants receive the vaccine and many children and adolescents have already received it. It is now required in South Carolina schools and some healthcare settings.

Human Papillomavirus (HPV) – More information is available at: www.cdc.gov/vaccines/vpd-vac/hpv/default.htm

Human Papillomavirus (HPV) is a common virus that is spread through sexual contact. Most of the time HPV has no symptoms, so people do not know they have it. There are approximately 40 types of genital HPV. Some types can cause cervical cancer in women and can also cause other kinds of cancer in both men and women. Other types can cause genital warts in both males and females. The HPV vaccine works by preventing the most common types of HPV that cause cervical cancer and genital warts. It is given as a 3-dose vaccine.

Varicella - More information is available at: www.cdc.gov/vaccines/vpd-vac/varicella/default.htm

Varicella (chickenpox) is a highly contagious disease that is very uncomfortable and sometimes serious, especially in young infants and adults. It causes a rash, itching, fever and tiredness. It can lead to severe skin infection, scars, pneumonia, brain damage or death. The chickenpox virus can be spread from person-to-person through the air or by contact with the fluid from the chickenpox blisters. A person who has had chickenpox can get a painful rash called shingles years later.

The chickenpox vaccine is the best protection against chickenpox. The vaccine is made from weakened varicella virus that produces an immune response in your body that protects you against chickenpox. The chickenpox vaccine was licensed for use in the United States in 1995. Since then, the vaccine has become widely used. Thanks to the chickenpox vaccine, the numbers of people who get chickenpox each year, as well as hospitalizations and deaths from chickenpox, have gone down dramatically in the United States.

Hepatitis A – More information is available at: www.cdc.gov/vaccines/vpd-vac/hepa/default.htm

Hepatitis A is an acute liver disease caused by the Hepatitis A virus (HAV), lasting from a few weeks to several months. It does not lead to chronic infection. Hepatitis A can affect anyone. Vaccines are available for long-term prevention of HAV infection in persons 1 year of age and older, travelers to certain countries, and others at risk. Transmission is through ingestion of fecal matter, (even microscopic amounts), from close person-to-person contact, or ingestion of contaminated food or drinks. Good personal hygiene and proper sanitation can help prevent the spread of Hepatitis A.

Although Hepatitis B, HPV, Varicella, Hepatitis A and annual Influenza vaccinations are not mandatory for entrance at Winthrop University, we follow the advice of the CDC and the American College Health Association (ACHA). That is, we recommend that our students receive these vaccinations.





HEALTH AND COUNSELING SERVICES

DIVISION OF STUDENT LIFE

217 Crawford Building

Rock Hill, SC 29733

Phone: 803/323-2206 Fax: 803/323-3332

For Office Use Only:

TB	-	_____	_____
MMR	-	_____	_____
MMR	-	_____	_____
Td/Tdap	-	_____	_____
Meningitis	-	_____	_____
Hep B	-	_____	_____
In ICM	-	___/___	___/___

FORM MUST BE COMPLETED IN FULL AND SUBMITTED BY THE FIRST DAY OF CLASSES

TO THE STUDENT: Proof of immunization or immunity is REQUIRED OF ALL STUDENTS in order to register for class. Any Immunization or TB requirement (IGRA blood test excluded) can be completed at Health Services located in Crawford Building. Note that documentation means a Healthcare Provider or Health Department must sign the form **OR** you must attach an official certificate (such as from the military or Health Department). Incomplete forms will be returned to you. Please mail, fax, or bring the completed form to Health Services after making a copy for your records.

PERSONAL DATA (Please print in black ink or type)

WU ID Number _____ Date of Birth _____ Winthrop Entrance Date _____

Full Name _____ Gender _____
Last First Middle

Address _____
Street City State ZIP

E-mail Address _____

Phones: Home _____ Cell _____ Work _____

Name(s) of next-of-kin/parent/guardian _____

Address _____
Street City State ZIP

Phones: Home _____ Cell _____ Work _____

Emergency Contact _____ Relationship _____

Phones: Home _____ Cell _____ Work _____

HEALTH INSURANCE COVERAGE Company _____

Address _____ Phone # _____

Policy Holder _____ Policy # _____

ALLERGIES: _____

CURRENT MEDICATIONS: _____

CURRENT MEDICAL CONDITIONS: _____

SIGNIFICANT PAST MEDICAL HISTORY: _____

I hereby authorize the medical staff of Winthrop University Health Services to provide medical treatment and/or procedures as necessary. I understand that there is no charge for an office visit, but that I may incur charges for lab tests, supplies or medicines which will be billed to my student account. Winthrop University Health Services does not accept or file health insurance claims but will provide the documentation necessary for me to file. I further authorize release of information to my insurance carrier if requested.

Student Signature _____ Date _____

Parent Signature _____ Date _____

If student under 18

Student's Name _____ Winthrop University ID Number _____

Date of Birth _____ Winthrop University Entrance Date _____

SCREENING MUST BE COMPLETED AND SIGNED BY STUDENT:

1A. Tuberculosis Screening Questionnaire

1) Have you lived in, traveled to or had household visitors from Asia, Africa, South America, Central America, the Caribbean, Eastern Europe, or the former Soviet Union within the past 5 years?	Yes	No
2) Have you experienced persistent cough, unexplained fever, night sweats, weight loss, bloody sputum (mucus)?	Yes	No
3) Have you had close contact with person(s) known to have or suspected of having tuberculosis?	Yes	No
4) Have you worked/volunteered in or been a resident of a long-term care facility, nursing home, homeless shelter, correctional institution, hospital or other healthcare facility, or residential facility for persons with AIDS?	Yes	No
5) Do you have any of the following conditions: diabetes, renal failure or dialysis, leukemia or lymphoma, other cancer, immunosuppressive therapy (including prednisone >15 mg./day for 1 month), silicosis, low body weight, gastrectomy, gastric bypass, jejunioleal bypass, HIV infection, injection drug use?	Yes	No

STUDENT SIGNATURE _____ **Date:** ____/____/____

1B. If you answered **Yes** to any of the above questions, **you must** have further assessment by a healthcare provider. **You will need a TB Skin Test or IGRA blood test within the last year unless you have had a positive TB Skin Test or IGRA blood test in the past.** If you had a positive TB test in the past and answered Yes to #2 above, you must get a chest x-ray. Please send written documentation of previous positive test and x-rays, treatment reports or evaluations related to the positive test.

TB SKIN TEST (if indicated):

PPD 0.1ml ID L or R forearm Placed by: _____ Date placed: ____/____/____ Time placed: _____

TB Skin Test result: _____ mm. induration Neg./Pos. Date read: ____/____/____ Time read: _____

SIGNATURE of healthcare professional reading test _____

OR Interferon Gamma Release Assay (IGRA) blood test (if indicated):

T Spot: Date: ____/____/____ Result ____ Report attached: **Yes** **OR** QuantiFERON GOLD: Date ____/____/____ Result: ____ Report attached: **Yes**

If any TB test is positive, a **CHEST X-RAY** must be obtained. **Send written report.** Date of X-ray ____/____/____ Report attached: **Yes**

IMMUNIZATIONS: TO BE COMPLETED AND SIGNED BY HEALTHCARE PROVIDER or ATTACH APPROPRIATE DOCUMENTATION

2. REQUIRED IMMUNIZATIONS:

2A. MMR: (Measles (Rubeola), Mumps, Rubella): two doses (or the equivalent) required. Doses given before first birthday are not valid.

Persons born before 1957 are exempt from this requirement. Proof of immunity may also be provided by a blood test called immune titers.

MMR #1 Dose given after 1967 and after 1st birthday Date: ____/____/____

MMR #2 Dose given at least 28 days after Dose #1 Date: ____/____/____

OR Immune Titers: **Must Attach Lab Reports:** Date: ____/____/____

2B. TETANUS-DIPHTHERIA: Booster within the last 10 years required.

Tdap (Adacel/Boostrix) Date: ____/____/____ **OR** **Td** Date: ____/____/____

2C. MENINGOCOCCAL VACCINE: Proof of a conjugate meningococcal vaccine (e.g. Menactra, Menveo) or a signed waiver declining the vaccine is required of all entering students age 25 years or younger. **If vaccine was received prior to age 16, a booster is highly recommended because immunity decreases over time.** A parent/legal guardian's signature is required if the student is under the age of 18 and declines this vaccination.

MCV4 (Menactra/Menveo) Date: ____/____/____ age: ____ **Booster Type:** _____ Date: ____/____/____

OR After reviewing the information provided about the dangers of meningococcal disease, I decline the vaccine or the booster at this time.

Student Signature _____ Date: ____/____/____

Parent Signature _____ Date: ____/____/____

If student under 18

3. Recommended but not mandatory:

HEPATITIS B: #1 ____/____/____ #2 ____/____/____ #3 ____/____/____ **OR** Titers: ____/____/____ Report Attached

HEPATITIS A: #1 ____/____/____ #2 ____/____/____

HPV: #1 ____/____/____ #2 ____/____/____ #3 ____/____/____

VARICELLA: #1 ____/____/____ #2 ____/____/____ **OR** History of Chickenpox: Yes/No **OR** Titers: ____/____/____ Report Attached

Signature of Healthcare Provider _____ Date _____

Print Name of Healthcare Provider _____

Address _____

Street

City

State

ZIP

Telephone _____

Fax _____

NOTE: This form will be scanned by Health Services and kept for 10 years, then destroyed. Please make a copy of this form before mailing the original to: Winthrop University, Division of Student Life, Health and Counseling Services, 217 Crawford Bldg., Rock Hill, SC 29733