For Office Use Only:

TB	-	__________	__________
MMR	-	__________	__________
MMR	-	__________	__________
Td/Tdap	-	__________	__________
Meningitis	-	__________	__________
Hep B	-	__________	__________
Date/In	-	_____/____	_____/____
In Comp	-	_____/____	_____/____

HEALTH AND COUNSELING SERVICES
DIVISION OF STUDENT LIFE
217 Crawford Building
ROCK HILL, SC 29733
PHONE 803/323-2206 FAX 803/323-3332

IMMUNIZATION FORM

TO THE STUDENT: **Proof of immunization or immunity is REQUIRED OF ALL STUDENTS** in order to register for class. **Any Immunization or TB requirement can be completed at Health Services**. Note that documentation means 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 M F
Last *First* *Middle*

Address ____
Street *City* *State* *ZIP*

Email 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____________________________ WU ID Number ________________

Date of Birth ______________________ Winthrop Entrance Date______________________

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, jejunoileal 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 within the last year *unless* you have had a positive TB Skin Test in the past. If you had a positive TB skin 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:____/____/____

TB Test result: ________mm. induration Neg./Pos. Date read: ____/____/____

SIGNATURE of healthcare professional reading test __________________________

If TB test is positive, **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:

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 blood test.

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: Attach Lab Reports Date: ____/____/____

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

Tdap – Date: ____/____/____ **OR** **Td**- Date: ____/____/____

2C. MENINGOCOCCAL VACCINE: See our web page (www.winthrop.edu/hcs/healthservices-immunizations.htm) for more information about meningococcal disease and meningitis.

Proof of immunization with meningococcal vaccine or a signed waiver declining the vaccine is required of all entering students under 25 years of age. Parent signature required for students under 18.

MCV4 (Menactra/Menveo) Date: ____/____/____ **OR** **MPSV4 (Menomune)** Date: ____/____/____

OR After reviewing the information provided about the dangers of meningococcal disease, I decline the vaccine.

Student Signature ______________________________ Date:____/____/____

Parent Signature ______________________________ Date:____/____/____

3. Recommended but not mandatory:

***HEPATITIS B**: See web page(www.winthrop.edu/hcs/healthservices-immunizations.htm) for more information.

Hepatitis B: three doses #1____/____/____ #2____/____/____ #3____/____/____

Signature of Healthcare Provider ____________________________Date ____________

Print Name of Healthcare Provider ____________________________

Address ____

Street City State ZIP

Telephone ____________________ Fax ____________________

NOTE: This form will be retained by Health Services 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