** IMMUNIZATION RECORD **

Must be completed and signed by Medical Professional

Name _____ SS# _____-_____-_____
(PRINT) Last First Middle

Date of Birth _____/_____/_____

Limestone College REQUIRES the following immunizations upon the recommendation of the American College Health Association and South Carolina Department of Health.

ALL DATES MUST INCLUDE MONTH, DAY AND YEAR

1. **TUBERCULIN PPD Required** - **(within past year)** - Results _____ mm _____ .... MO _____ Day _____ Yr _____
   Tine Test NOT Accepted

   NOTE: *If PPD positive, a chest x-ray is required 3 months prior to class enrollment.*
   Copy of x-ray results must be sent to Limestone College Student Health Services.

2. **M.M.R.** (Mumps, Measles, Rubella) - PROOF of 2 doses after 1st birthday

   ☐ **Dose 1 - *Immunized at 12 months of age or later, and*** ..... MO _____ Day _____ Yr _____

   ☐ **Dose 2 - *Immunized at 12 months of age or later, and*** ..... MO _____ Day _____ Yr _____

   OR as SINGLE DOSES as listed below —

   #1 #2

   A. Measles - PROOF of 2 doses after 1st birthday

   ☐ *Immunized with Live Measles Vaccine at 12 months of age or later, AND*..... MO _____ Day _____ Yr _____

   ☐ *Immunized with second dose of Live Measles Vaccine 30 days after first dose or later*..... MO _____ Day _____ Yr _____

   B. Mumps

   ☐ *Had disease, confirmed by physician diagnosis in office record, OR* ..... MO _____ Day _____ Yr _____

   ☐ *Immunized with vaccine at 12 months of age or later* ..... MO _____ Day _____ Yr _____

   C. Rubella

   ☐ *Immunized with vaccine at 12 months of age or later* ..... MO _____ Day _____ Yr _____

3. **TETANUS** - DTP - (Circle No. of Doses Received: 1 2 3 4 5) Date of last dose ..... MO _____ Day _____ Yr _____

   Booster (Must be given within the last 9 years) - DTP, DT, or Td (Circle one)..... MO _____ Day _____ Yr _____

4. **POLIO** - (OPV, TOPV) (Circle No. of Doses Received: 1 2 3 4 5) Date of last dose ... MO _____ Day _____ Yr _____

5. **HEPATITIS B** #1 _____ #2 _____ #3 _____

6. **MENINGITIS (highly recommended)** ..... MO _____ Day _____ Yr _____

If you cannot provide Immunization Record, you will be required to have all vaccines or sign a release.

I certify the above information is correct. _____
Physician's Signature or Clinic Stamp ***Required***