Limestone University Immunization Record

(Must be completed and signed by a Health Care Professional)

Name: _____ SS#_____-____-____

Date of Birth _____/_____/_____ Student ID# _____

Limestone University 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. Tetanus-Diphtheria: Booster with TDAP in the last 10 years
   Date: Mo ____ Day ____ Year ____
2. M.M.R. (measles, mumps, rubella) – Proof of 2 doses after 1st birthday
   Dose 1: Mo ____ Day ____ Year ____
   Dose 2: Mo ____ Day ____ Year ____
3. Polio – (OPV, TOPV) (Circle number of doses received: 1 2 3 4 5)
   Date of last dose: Mo ____ Day ____ Year _____
4. Hepatitis B # 1 _____ # 2 _____ # 3 _____
5. Meningitis **(highly recommended)** Mo ____ Day ____ Year ____
6. Tuberculosis screening questionnaire (see next page) **NOTE: If you have had a positive PPD/TB test you must submit a copy of your chest x-ray report prior to registration.**
7. COVID Vaccine Type: _____ Date: _____ Dose # 1 _____
   Dose # 2 _____ (if needed) * **This vaccine is NOT required but highly recommended***

** A completed vaccination, **negative** COVID test result, or proof of antibodies is required before returning to Campus. The negative COVID result or proof of antibodies must be dated 10 days prior to arriving on campus. If you have completed the vaccine(s), you will need to send a copy of your vaccine voucher to the Health Center via mail or email it to healthcenter@limestone.edu .**

The above vaccines are **REQUIRED OR RECOMMENDED** as part of Limestone University's mandatory Health Form. There are additional vaccines that are recommended by the CDC and we encourage you to discuss these vaccines with your health care professional.

I certify the above information is correct _____

(Physician's Signature or Office Stamp Required)