USCB International Student Immunization Requirements

Section I - Information and Instructions

The University of South Carolina Beaufort requires all international students born after December 31, 1956, to furnish proof of receiving two doses of measles (rubeola) and one dose of German measles (rubella) vaccine after their 1st birthday prior to registration for classes.

Proof of immunity requires documentation of one of the following:

1. Receiving two measles and one German measles (MR or MMR vaccine) shot after 1967 and 1st birthday. This reflects newly updated 1989 measles immunization requirement.
2. Positive serum titer (blood antibody) to measles and German measles, or
3. Physician-diagnosed measles illness plus meeting one of the above criteria for German measles. History of German measles illness does not meet requirements.

Please complete the following form and return it with your application to:

Aaron Marterer, Registrar
University of South Carolina Beaufort
1 University Boulevard
Bluffton, SC 29909 USA
Telephone: (843) 521-4102
Fax: (843) 521-4194
marterer@sc.edu

Required Immunization Information

Applicant for:  Fall _____ Spring _____ Summer ____  Year ________
Name of student: ___________________________________________________________________
Social Security number (if available): _______________________________________
Date of birth: ____________________________  Male ____  Female ____
Telephone: _____________________________  Email: _______________________________________

____ I have been vaccinated for both measles and German measles. A photocopy of my immunization information is attached. (Copy must be legible, in English and with no modifications.)
____ My immunization information, certified by a licensed health professional, is listed below.

<table>
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| 1. MEASLES (Rubeola) date of immunization: #1 ___________________ #2 ___________________  
| or date of disease: __________________________ date of positive serum titer: __________________________ |
| 2. GERMAN MEASLES (Rubella) Date of immunization: ___________________ or date of positive serum titer: ___________________. History of disease is not acceptable. |
| 3. (MMR includes Measles, Mumps and Rubella) Date of immunization: ___________________ |

I certify that the above is correct:

Doctor’s signature: ______________________________________  Date: ___________________________
Doctor’s address or stamp: _______________________________________________________________
All international students must comply with the tuberculosis requirements in Section A of this form. Section B vaccines are recommended, but not mandatory.

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**Section A – Mandatory tuberculosis requirements**

A PPD test (Mantoux) within the past 12 months is required, regardless of prior BCG inoculation. The tine test or the monovac test is not acceptable. Students with a positive PPD test are required to have a chest x-ray examination.

1. **BCG inoculation status:**
   - [ ] Received BCG  ______ month ______ year
   - [ ] No BCG inoculation

2. **Date of PPD test:** ______ month ______ year

3. **PPD test results:** ______ mm induration:/// ______ Neg. ______ Pos.
   - If PPD test is positive, chest x-ray is required.
     - **Date of x-ray examination:** ______ month ______ year
     - **X-ray examination results:** ______ Neg. ______ Pos.

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**Section B – Vaccines that are recommended but not mandatory**

1. **Mumps:** Immunity is shown by meeting one of the following:
   a. Immunized by live vaccine at 12 months after birth or later.
      - **Date of vaccination:** ______ day ______ month ______ year
   b. Positive immune titer.
      - **Date of titer:** ______ day ______ month ______ year
   c. Disease confirmed by Doctor’s records.
      - **Date of disease:** ______ day ______ month ______ year

2. **Tetanus-Diptheria:** Basic series or last booster must have been within the last ten years.
   a. **Completed primary series:** ______ yes ______ no
   b. **Last booster:** ______ month ______ year

3. **Polio:** Completed primary series: ______ yes ______ no
   a. **Date of last booster:** ______ month ______ year
   b. **Type of vaccine:** ______ live (OPV) ______ inactive (IVP) ______ enhanced potency (EP-IPV)

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I certify that the above additional information is correct:

**Doctor’s signature:** _________________________________________  **Date:** _____________________

**Doctor’s address or stamp:** _____________________________________________________________

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