SOUTH COLLEGE SCHOOL OF PHARMACY

MANDATORY PHARMACY STUDENT IMMUNIZATION DOCUMENTATION FORM

NAME:

SOUTH COLLEGE SCHOOL OF PHARMACY ADMISSION REQUIREMENTS

Complete and submit documentation a minimum of 30 days prior to orientation.

1. **MMR**
   Two immunizations are required OR documentation of immunity confirmed by titer

   MEASLES (RUBEOLA)
   □ Immunization 1 - Date _____
   □ Immunization 2 - Date _____
   OR
   □ Immunity confirmed by titer
   Attach copy of lab report

   MUMPS
   □ Immunization 1 - Date _____
   □ Immunization 2 - Date _____
   OR
   □ Immunity confirmed by titer
   Attach copy of lab report

   GERMAN MEASLES (RUBELLA)
   □ Immunization 1 - Date _____
   □ Immunization 2 - Date _____
   OR
   □ Immunity confirmed by titer
   Attach copy of lab report

2. **VARICELLA ZOSTER (CHICKEN POX)**
   Two immunizations are required
   OR immunity confirmed by titer
   □ Immunization 1 - Date _____
   □ Immunization 2 - Date _____
   OR
   □ Immunity confirmed by titer
   Attach copy of lab report

3. **TETANUS, DIPHTHERIA, AND PERTUSSIS**
   One dose of Tdap is required every 10 years.
   □ Immunization - Date _____
   OR
   □ Exempt Status ***Attach physician's statement***

4. **HEPATITIS B**
   Three immunizations are required
   AND documentation of immunity by titer
   □ Immunization 1 - Date _____
   □ Immunization 2 - Date _____
   □ Immunization 3 - Date _____

5. **HEPATITIS B TITER REPORT**
   □ Immunity confirmed by titer and report attached - **Required**

****If titers negative or equivocal, vaccination series will need to be repeated with subsequent titers.*

Additional Required documents to be provided by the student:

A. **Health Insurance Information**
   All students are required to have current health insurance.
   Please attach a front/back copy of health insurance card.

B. **State Issued Driver's License**
   Please attach a front/back color copy of driver's license.

Please email completed health and immunization forms to:lthomas@south.edu

If unable to submit via email, please contact Lisa Thomas at lthomas@south.edu or (865) 288-5812 for alternative delivery options.

Any questions related to the completion of this form should be directed to the School of Pharmacy Student Records Specialist at lthomas@south.edu

CERTIFICATION BY HEALTH CARE PROFESSIONAL

Name of Health Care Provider Filling out Form:

_____

Name and address of Institution or Clinic (or stamp):

_____

_____

Phone _____Fax _____

I certify that this information is complete and correct to the best of my knowledge.
Date_____

Signature_____

License #_____