IMMUNIZATION FORM

Last Name	First Name	Date of Birth	XID

REQUIRED IMMUNIZATIONS

VACCINE	DATE MM/DD/YYYY	DATE MM/DD/YYYY	DATE OF POSITIVE LAB/SEROLOGIC EVIDENCE	
MMR (Required if born after 1956 or positive titer)	12 Months or Older / /	minimum 1 month after 1st dose / /		
Measles	/ /	/ /	/ /	☐ Copy of Report Attached
Mumps	/ /	/ /	/ /	☐ Copy of Report Attached
Rubella	/ /	/ /	/ /	☐ Copy of Report Attached
Tdap (Required for ages 64 and younger)	/ /			
Meningococcal (Required if 21 or younger or waiver)	/ /	Vaccine Type: ☐ Menactra ☐ Menveo ☐ MenQuadfi	Booster required if given before age 16 / /	Booster Type: ☐ Menactra ☐ Menveo ☐ MenQuadfi

RECOMMENDED IMMUNIZATIONS

VACCINE	DATE MM/DD/YYYY	DATE MM/DD/YYYY	DATE MM/DD/YYYY	DATE OF POSITIVE LAB/SEROLOGIC EVIDENCE	
HEPATITIS A	/ /	/ /	/ /	/ /	☐ Copy of Report Attached
HEPATITIS B	/ /	/ /	/ /	/ /	☐ Copy of Report Attached
HEP A-B	/ /	/ /	/ /		
VARICELLA	/ /	/ /		/ /	☐ Copy of Report Attached
HPV	/ /	/ /	/ /	Series Type: ☐ GARDASIL ☐ CERVARIX ☐ 9-VALENT	
Meningococcal B	/ /	/ /	/ /	Series Type: ☐ Trumenba ☐ Bexero	

HEALTHCARE PROVIDER SIGNATURE OR STAMP REQUIRED

Name:____________________ **Signature**: ____________________

Address:____________________ **Phone**: ____________________

Box 344054, Clemson, SC 29634-4054
P: 864-656-2233 F: 864-656-0760
DIVISION OF STUDENT AFFAIRS

MEDICAL HISTORY QUESTIONNAIRE

Name *(Last, First, M.I.)*:			M ☐	F ☐	**DOB:**
XID:					
CU status:	☐ Student	☐ Spouse	☐ Worker's Comp	☐ Visitor on Campus	☐ Exchange Visitor

PERSONAL MEDICAL HISTORY		
☐ **ADHD**	☐ **HEADACHES/MIGRAINES**	☐ **NEUROLOGICAL DISORDER**
☐ **ALCOHOL/DRUG USE**	☐ **HEARING DISABILITIES**	☐ **PROLONGED IMMUNOSUPPRESSIVE/ CORTICOSTEROID TREATMENT**
☐ **ASTHMA**	☐ **HEPATITIS B** ☐ **CARRIER**	☐ **PSYCHOLOGICAL/EMOTIONAL CONCERNS**
☐ **CHICKEN POX**	☐ **HEPATITIS C**	☐ **SEIZURES**
☐ **CHRONIC FATIGUE**	☐ **HIGH BLOOD PRESSURE**	☐ **SKIN DISORDERS**
☐ **DIABETES**	☐ **HIGH CHOLESTEROL**	☐ **SMOKING/TOBACCO USE**
☐ **EATING DISORDERS**	☐ **HIV POSITIVE**	☐ **THYROID DISORDER**
☐ **EYE DISEASE**	☐ **KIDNEY DISEASE**	☐ **MALARIA**
☐ **HEAD INJURY WITH UNCONSCIOUSNESS**	☐ **MONONUCLEOSIS**	☐ **VISION/CORRECTIVE LENSES**

Significant Illnesses:

Surgeries: **Year:**

FAMILY MEDICAL HISTORY		
☐ **ALCOHOL/DRUG PROBLEM**	☐ **DIABETES**	☐ **HIGH BLOOD PRESSURE**
☐ **ASTHMA/HAY FEVER**	☐ **HEART DISEASE/STROKE**	☐ **HIGH CHOLESTEROL**
☐ **CANCER**	☐ **HEREDITARY DISEASE**	☐ **MIGRAINE HEADACHES**
☐ **OTHER SIGNIFICANT ILLNESSES (LIST)**		

List Any Other Medical Problems:

ALLERGIES (DRUGS AND OTHER SEVERE ADVERSE REACTIONS)		
☐ **NO KNOWN DRUG ALLERGIES**	☐ **PENICILLIN**	☐ **LATEX**
☐ **ACETAMINOPHEN**	☐ **SULFA**	☐ **X-RAY CONTRAST**
☐ **ASPIRIN**	☐ **FOOD (LIST BELOW)**	☐ **OTHER (SPECIFY BELOW)**
☐ **LIDOCAINE/XYLOCAINE**	☐ **INSECT/BEE STING**	

List Any Other Allergies:

Are you currently taking any medications? ☐ **YES** ☐ **NO** **(IF SO, PLEASE LIST BELOW)**

Signature of Patient/Guardian

Date

Print Name of Patient/Guardian

Please visit our website at *clemson.edu/studenthealth*.

REDFERN HEALTH CENTER

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