South Carolina Certificate of Immunization (DHEC 4024)
INSTRUCTIONS FOR COMPLETING

Purpose
To provide valid documentation of immunizations for childcare and school attendance in SC.
(*) Asterisk denotes items that cannot be completed by school nurses.

Certification
Check appropriate box(es) in the Certification Status section after reviewing the child's vaccination documentation and South Carolina School and Childcare attendance requirements.

- **Certificate Expires*(Must Hand Write)**: Check this box if child has not received complete immunizations for childcare or school and does not have anymedical exemptions.
  - "Date next immunization is due" section MUST be completed. **The child may attend childcare or school for no more than one month from the date listed**.
  - *The date written should correspond to the date the next immunization is due and written as* ***mm/dd/yyyy***
  - **Applies ONLY to immunizations required for childcare or school in South Carolina**

Reference the SC School and Childcare attendance requirements for current school year to determine the correct response for below:

- Meets Childcare Requirements: Check this box if child meets all the immunization requirements for childcare.
- Meets School Requirements: Check the applicable box for which the child meets all the immunization requirements for school.
  - ***Select the appropriate box based on the child's grade***

- Medical Exemption*****: Check this box if child has a temporary or permanent medical exemption.

Section 1: Identification/ Name (Auto Populates)
Name
Enter child's full name.
Date of Birth
Enter child's date of birth.
SIMON ID#
Record child's assigned SIMON ID, if applicable.

Section 2: Vaccination Date (Auto Populates)
Vaccine Date: Document month/day/year (e.g., 12/23/2002) for each immunization administered that corresponds to the appropriate vaccine.

- Varicella ("Chickenpox"): If child has a reliable history of Varicella disease, circle YES in this section.
  Reliable history of Varicella is defined as: (1) Healthcare provider diagnosis or verification of Varicella disease or (2) laboratory evidence of immunity or laboratory confirmation of disease.
- If a child has documentation of a positive titer, hand write month/day/year (e.g., 12/23/2002) and the "Positive Titer" on the line corresponding to the vaccine. If a child has a positive titer for a vaccine with multiple antigens, the disease for which there is a positive titer must also be included on the line (e.g., positive titer for mumps only – write "Positive Titer – Mumps 12/23/2002" on the MMR line).

Medical Exemption* (Must Hand Write)
If applicable, document the name of the vaccine(s) if there is a permanent or temporary medical reason for exclusion. This section **must** be approved by the licensed Physician (MD or DO) or his/her authorized representative (e.g., **Physician's Assistant** or **Advanced Practice Registered Nurse**).

- Temporary Exemption: This section should only be used if the vaccine(s) listed is/are temporarily exempt. A date must be documented indicating when the temporary exemption for the vaccine(s) expires.
- Permanent Exemption: This section should only be used if the vaccine listed is permanently exempt. A check mark should be placed in the box indicating this is permanent and does not have an expiration period.

Physician/Authorized Representative Information (Must Hand Write)
Print Physician's Name: *The physician is the licensed Practitioner of Medicine, Surgery, or Osteopathy.* **The physician's name area must be completed to be valid**.

- DHEC staff: Print the following - "DHEC Regional Medical Director"
- Authorized School Nurses who completed DHEC training pursuant to memorandum of agreement with school district: Print the following - "DHEC Regional Medical Director"
- Private Practices: Print name of specific physician certifying certificate

Authorized Representative (Must Hand Write): *The physician authorizes this individual to complete the certificate*. **The Authorized Representative's namemust be printed if someone other than the certifying physician is issuing the certificate.**

- **Example** – The physician authorizes his/her nurse to complete the certificate. The physician's name and the nurse's name (as authorized representative) must be printed. The nurse's signature is required as the authorized representative for that physician.

Facility Telephone Number/ Name/ Address: (Auto Populates)

- DHEC staff: Regional Health Department telephone number, name and address
- Authorized School Nurses who completed DHEC training pursuant to memorandum of agreement with school district: School telephone number, name, and address
- Private Practices: Office telephone number, name, and address

Signature: The person completing the certificate must sign the form (either physician or authorized representative)
Date Certificate Issued (Auto Populates): *Certificate cannot be issued if immunization dates in the Vaccination Date (Section 2) are after the date the certificate is issued.*
Replication Approval Code: If provider or electronic health record (EHR) vendor replicates this certificate, a replication approval code must appear on each certificate generated from EHR.
Office Mechanics: Provide the parent, legal guardian, or person in loco parentis with the certificate of immunization.