University of South Dakota Health Affairs
REQUIRED IMMUNIZATION FORM

Name: ___________________________  DOB: ________  USD ID#: ____________

Program:  Addiction Studies [ ]  Dental Hygiene [ ]  Health Science [ ]  Medical Laboratory Science [ ]  Medicine [ ]
Nursing [ ]  Physical Therapy [ ]  Physician Assistant [ ]  Occupational Therapy [ ]  Social Work [ ]  Master of Social Work [ ]

Health Affairs Requirements: For students in programs requiring full compliance with the USD Health Affairs Immunization Policy, this form must be completed with the appropriate signatures. Include copies of titer reports and other medical records when applicable.

REQUIRED IMMUNIZATIONS:

A. **MMR (Measles, Mumps, Rubella) Vaccine.** Two doses required for all students born after 12/31/56.
   Dates: 1.____/____/_____  2. _____/_____/_____
   OR individual vaccine/proof of immunity as noted below.
   1. **Measles (Rubeola)**
      Vaccine Dates: 1.____/____/_____  2._____/_____/_____  
      OR
      Has report of positive immune titer. Date:___/____/_____  ATTACH LAB REPORT
   2. **Rubella (German Measles)**
      Vaccine Dates: 1.____/____/_____  2._____/_____/_____  
      OR
      Has report of positive immune titer. Date:___/____/_____  ATTACH LAB REPORT
   3. **Mumps**
      Vaccine Dates: 1.____/____/_____  2._____/_____/_____  
      OR
      Has report of positive immune titer. Date:___/____/_____  ATTACH LAB REPORT

B. **Date of Tdap (tetanus, diphtheria, adult pertussis):** Date:_____/____/_____  
   † If longer than 10 years; date of latest booster Date:_____/____/_____  Td or Tdap (circle one)

C. **Varicella (Chicken Pox) One of the following is required:**
   Documentation of positive varicella titer. Date:____/____/_____  ATTACH LAB REPORT
   OR
   Vaccine: Two doses are required for those without evidence of immunity. Recommended interval is 4-8 weeks between doses.
   Dates: 1.____/____/_____  2._____/_____/_____  

D. **Hepatitis B Vaccine** - Three doses and positive titer required. *(If unable to obtain dates of immunizations a positive titer is acceptable)*
   1st dose Date:____/____/_____  
   2nd dose Date:____/____/_____  (1 month after 1st dose)
   3rd dose Date:____/____/_____  (6 months after 1st dose)
   **AND**
   Hepatitis B Titer (HbsAB or Anti-HBs – hepatitis B surface antibodies)
   Immunity demonstrated by hepatitis B titer - ATTACH LAB REPORT
   Date:____/____/_____  Positive/Reactive_____  Negative/Nonreactive_____
   (if neg. see immunization policy)

Updated 6/1/2015
E. **Tuberculosis Skin Test** - PPD (Mantoux) – Two-step TB skin test required initially or Interferon Gamma Release Assay

Two-Step TB Skin Test; recommended 1-3 weeks apart.*Note any two documented TB skin tests completed within a 12 month period shall be considered a two-step.

† Step 1 (Date placed) ___/___/____  Step 1 (Date read) ___/___/____  Results: _____________mm

Step 2 (Date placed) ___/___/____  Step 2 (Date read) ___/___/____  Results: _____________mm

If two-step was completed more than 12 months prior to start of classes, an annual TB skin test is required

Date placed _____/_____/_____  Date read _____/_____/_____  Results: _____________mm

Interferon Gamma Release Assay (IGRA):  Date: _____/_____/_____  Positive_____  Negative_____

**ATTACH LAB REPORT**

**History of Positive TB Skin Test:**

Date placed _____/_____/_____  Date read _____/_____/_____  Results: _____________mm

**ATTACH COPY OF CHEST X-RAY REPORT AND DOCUMENTATION FROM HEALTHCARE PROVIDER.**

See immunization policy.

History of BCG vaccination:  Date _____/_____/_____  (TB skin test required regardless of prior BCG vaccination)

F. **Influenza vaccine.** Required by Dec. 1st annually  Date: _____/_____/_____  

*Not required prior to admission if starting in the summer or fall*

**RECOMMENDED IMMUNIZATIONS:**

G. **Meningococcal Vaccine (Meningitis vaccine).** Recommended for students living in college dormitories who have not been immunized previously or for college students under 25 years of age who wish to reduce their risk.

Date: _____/_____/_____  

H. **Childhood DTP/TDaP/DPT immunizations:**

Dates of Primary Series:  1.____/_____/_____  2._____/_____/_____  3._____/_____/_____  4._____/_____/_____  5._____/_____/_____  

I. **Polio immunizations:**

Dates of Primary Series:  1.____/_____/_____  2._____/_____/_____  3._____/_____/_____  4._____/_____/_____  5._____/_____/_____  Type of vaccine:  Oral (OPV)_____  Inactivated (IPV)_____

**SIGNATURE**  X ___________________________________________  Date _____/_____/_____  

*Must be signed by Healthcare Provider (Physician, PA, NP, Nurse)*

**PRINT NAME**  ___________________________________________

**Hospital/Clinic Address of physician or nurse verifying this information:**  Hospital/Clinic Phone # __________________________

**A copy of titer/lab reports must be provided with this form as indicated above.**

Updated 6/1/2015