

**University of South Dakota Health Affairs
REQUIRED IMMUNIZATION FORM**

Name _____ Date of birth _____ USD ID# (orSS#) _____

Program: Alcohol Drug Studies Dental Hygiene Clinical Laboratory Science Medicine
Nursing Occupational Therapy Physical Therapy Physician Assistant Social Work

Health Affairs Requirements:

- Students are required to follow the Immunization Compliance Policy of their specific program.
- 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.

a. **Measles** (Rubeola). Check all that apply:

Vaccine Dates: 1. ___/___/___ 2. ___/___/___

Has report of positive immune titer. Date: ___/___/___ *attach copy of titer report*

b. **Rubella** (German Measles) Clinical history is not acceptable. Check all that apply.

Vaccine Dates: 1. ___/___/___ 2. ___/___/___

Has report of positive immune titer. Date: ___/___/___ *attach copy of titer report*

c. **Mumps** Check all that apply.

Vaccine Dates: 1. ___/___/___ 2. ___/___/___

Has report of positive immune titer. Date: ___/___/___ *attach copy of titer report*

B. **Diphtheria-Tetanus-Pertussis**

Dates of primary series: 1. ___/___/___ 2. ___/___/___ 3. ___/___/___

4. ___/___/___ 5. ___/___/___ Last Tetanus Booster (TT, Td) ___/___/___

AND

Date of Tdap (tetanus, diphtheria, adult pertussis): Date: ___/___/___

C. **Polio**

Dates of primary series: 1. ___/___/___ 2. ___/___/___ 3. ___/___/___

4. ___/___/___ Type of vaccine: Oral (OPV) ___ Inactivated (IPV) ___

Booster (**optional**): Date: ___/___/___; Type of vaccine: Oral (OPV) ___ Inactivated (IPV) ___

D. **Varicella** (Chicken Pox) One of the following is required:

Documentation of positive varicella titer. Date: ___/___/___ *attach copy of titer report*
(if negative, varicella immunization required)

OR

Vaccine: Two doses are required at an interval of 4-8 weeks for people ≥ 13 years of age without evidence of immunity.

Dates: 1. ___/___/___ 2. ___/___/___

Name _____

E. Hepatitis B Vaccine - Three doses and positive titer required.

Name and Address of where immunization was obtained:

- 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 – antibody to hepatitis B surface antigen)

- Immunity demonstrated by hepatitis B titer - attach copy of titer report.
Date: ____/____/____ Positive/Reactive _____ Negative/Nonreactive _____ (if neg. see immunization policy)

F. Tuberculosis Skin Test - PPD (Mantoux) – Two-step TB skin test required initially or TB Gold Blood Test.

- Two-Step TB Skin Test *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 class, one TB skin test within the past 12 months is required.

Date placed ____/____/____ Date read ____/____/____ Results: _____ mm

OR

- QuantiFERON-TB Gold Blood Test (QFT-G): Date: ____/____/____ Positive _____ Negative _____
Attach copy of report.
- History of Positive TB Skin Test: Date ____/____/____
Documentation of chest x-ray & treatment required.
- History of BCG vaccination: Date ____/____/____
TB skin test required regardless of prior BCG vaccination.

RECOMMENDED IMMUNIZATIONS:

- 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: ____/____/____
- Influenza vaccine. Recommended annually for healthcare providers.
Date: ____/____/____

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

SIGNATURE X _____
Must be signed by Physician or Nurse

Date ____/____/____

PRINT NAME _____

Hospital/Clinic Address of physician or nurse verifying this information:

Telephone number of hospital/clinic _____