University of South Dakota
REQUIRED IMMUNIZATION FORM

☐ **Audiology** ☐ **Speech Language Pathology**

Name _____ **DOB** _____ **USD ID#** _____

Students in Audiology and Speech Language Pathology are required to comply with the USD Health Affairs Immunization Policy. This form must be completed with 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)
OR
Vaccine Dates: 1.____/_____/_____ 2._____/_____/_____
Has report of positive immune titer. Date:____/_____/_____ *Attach lab report*

b. **Rubella** (German Measles)
Vaccine Dates: 1.____/_____/_____ 2._____/_____/_____
OR
Has report of positive immune titer. Date:____/_____/_____ *Attach lab report*

c. **Mumps**
Vaccine Dates: 1.____/_____/_____ 2._____/_____/_____
OR
Has report of positive immune titer. Date:_____/_____/_____ *Attach lab report*

B. T**etanus, 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:** 3 doses of Engerix-B, Recombivax, or Twinnix or 2 doses of Heplisav-B followed by a QUANTITATIVE Hepatitis B Surface Antibody (titer) preferably drawn 4-8 weeks after last dose. If negative, give a 4th dose and repeat titer in 4-8 weeks. If negative, complete the remainder of the second series followed by another titer drawn 4-8 weeks after the last dose of the second series. If Hepatitis B Surface Antibody is still negative after a secondary series, additional testing including Hepatitis B Surface Antigen should be performed.

Primary HBV series:	1st dose	Date:_____/_____/_____
(Heplisav-B requires only 2 doses)	2nd dose	Date:_____/_____/_____(1 month after 1st dose)
	3rd dose	Date:_____/____ /_____ (6 months after 1st dose)
Secondary HBV series:	4th dose	Date:____/_____/_____
(only if no response to primary series)	5th dose	Date:____/____/_____
(Heplisav-B requires only 2 doses)	6th dose	Date:____/____/_____

AND

Hepatitis B Surface Antibody (titer)

Quantitative immunity demonstrated by Hepatitis B titer - *attach copy of titer report*.

Date:_____/_____/_____ Positive/Reactive_____ Negative/Nonreactive_____ (if neg. see immunization policy)
Date:_____/_____/_____ Positive/Reactive_____ Negative/Nonreactive_____ (if neg. see immunization policy)

E. **Tuberculosis Test:** Two-step TB skin test required initially ***or*** QuatiFERON TB Gold Blood Test.
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 class, one TB skin test within the past 12 months is required.
Date placed _____/_____/_____ Date read _____/_____/_____ Results:_____mm

OR

QuantiFERON TB Gold or T-Spot: Date:_____/_____/_____ A*ttach copy of report*
(Interferon Gamma Release Assay)

Additional testing, if negative or indeterminate

QuantiFERON TB Gold or T-Spot: Date:_____/_____/_____ A*ttach copy of report*
(Interferon Gamma Release Assay)

History of Positive TB Skin Test**:** Date _____/_____/_____*Documentation of chest x-ray & treatment/duration required*.

F. **Influenza vaccine**- Required annually. (Not required prior to admission if starting in the summer or fall semester.) Date:_____/_____/_____

RECOMMENDED IMMUNIZATION:

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:_____/_____/_____

SIGNATURE: _____ Date:_____
*Must be signed by **Healthcare Provider (Physician, PA, NP, Nurse)***

PRINT NAME:_____ Title:_____

Hospital/Clinic Address of individual verifying this information:

_____
_____
_____
_____

Telephone number of hospital/clinic:_____

Email contact:_____

Updated 10/2020