University of South Dakota

School of Health Sciences

REQUIRED IMMUNIZATION FORM

Name_____ **Date of Birth**_____**USD ID#**_____

Street Address_____ **City** _____

State_____ **Zip code** _____

Program:

___ Addiction Counseling and Prevention (B.S., M.A.)
___ ABA Certificate
___ Clinical Research Coordinator Certificate
___ Dental Hygiene (B.S.)
___ Health Sciences (B.S.; M.S.)
___Medical Laboratory Science (B.S.)
___ Nursing (B.S.N.; M.S.N.; D.N.A.P.; D.N.P)
___ Occupational Therapy (O.T.D.)
___ Physical Therapy (D.P.T.)
___ Physician Assistant (M.S.)
___ Public Health (B.S.; M.P.H.)
___ Social Work (B.S.; M.S.W.)

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.

a. **Measles** (Rubeola)
Vaccine dates: 1. _____/_____/_____ 2. _____/_____/_____
OR
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. Tetanus, diphtheria, adult pertussis: Date: _____/_____/_____
If longer than 10 years, date of latest booster: Date: _____/_____/_____

Student's Name

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.

Series received (mark one): _____ Energix-B, Recombivax, or Twinnix (3 doses required)
_____ Heplisav-B (2 doses required)

Primary HBV series: 1st dose Date: _____/_____/_____
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: _____/_____/_____
6th dose Date: _____/_____/_____

AND
Hepatitis B Surface Antibody (titer)
Quantitative immunity demonstrated by Hepatitis B titer - ***attach copy of titer report.***
**If negative/nonreactive, see immunization policy*
Date: _____/_____/_____Positive/Reactive_____Negative/Nonreactive_____
Date: _____/_____/_____Positive/Reactive_____Negative/Nonreactive_____

D. Tuberculosis Test: Two-step TB skin test required initially ***or*** QuantiFERON TB Gold Blood Test. Two-Step TB Skin Test need to be completed 1-3 weeks apart. **Note:* any two documented TB skin tests completed within a 12-month period shall be considered a two-step if tests are completed 1-3 weeks apart.

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: _____/_____/_____***Attach copy of report***
(Interferon Gamma Release Assay)

Student's Name

Additional testing, if positive or indeterminate

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

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

E. Influenza vaccine- **Required annually by October 15**. (Not required prior to admission if starting in the summer or fall semester.) Date: _____/_____/_____

RECOMMENDED IMMUNIZATIONS:
Covid-19 Vaccine. Highly recommended for all students.
Manufacturer _____

Date____/_____/_____ Date ____/_____/_____ Date ____/_____/_____

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 2/2024