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.) ___ Nursing (B.S.N.; M.S.N.; D.N.A.P.; D.N.P)
___ ABA Certificate ___ Occupational Therapy (O.T.D.)
___ Clinical Research Coordinator Certificate ___ Physical Therapy (D.P.T.)
___ Dental Hygiene (B.S.) ___ Physician Assistant (M.S.)
___ Health Sciences (B.S.; M.S.) ___ Public Health (B.S.; M.P.H.)
___ Medical Laboratory Science (B.S.) ___ 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 (Rubella)  
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.  

<table>
<thead>
<tr>
<th>Series received (mark one):</th>
<th>_____ Engerix-B, Recombivax, or Twinnix (3 doses required)</th>
<th>_____ Heplisav-B (2 doses required)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary HBV series:</td>
<td>1st dose Date: <strong><strong>/</strong></strong>/_____</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2nd dose Date: <strong><strong>/</strong></strong>/_____(1 month after 1st dose)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3rd dose Date: <strong><strong>/</strong></strong>/_____ (6 months after 1st dose)</td>
<td></td>
</tr>
<tr>
<td>Secondary HBV series:</td>
<td>4th dose Date: <strong><strong>/</strong></strong>/_____</td>
<td></td>
</tr>
<tr>
<td>(only if no response to primary series)</td>
<td>5th dose Date: <strong><strong>/</strong></strong>/_____</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6th dose Date: <strong><strong>/</strong></strong>/_____</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Date: <strong><strong>/</strong></strong>/_____</th>
<th>Positive/Reactive</th>
<th>Negative/Nonreactive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date: <strong><strong>/</strong></strong>/_____</td>
<td>Positive/Reactive</td>
<td>Negative/Nonreactive</td>
</tr>
</tbody>
</table>

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.  

<table>
<thead>
<tr>
<th>Step 1 (Date placed)</th>
<th><strong><strong>/</strong></strong>/_____</th>
<th>Step 1 (Date read)</th>
<th><strong><strong>/</strong></strong>/_____</th>
<th>Results: _____ mm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 2 (Date placed)</td>
<td><strong><strong>/</strong></strong>/_____</td>
<td>Step 2 (Date read)</td>
<td><strong><strong>/</strong></strong>/_____</td>
<td>Results: _____ mm</td>
</tr>
</tbody>
</table>

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)  

<table>
<thead>
<tr>
<th>Student’s Name</th>
</tr>
</thead>
</table>

Additional testing, if positive or indeterminate
QuantiFERON TB Gold or T-Spot: Date: _____/_____/
Interferon Gamma Release Assay
Attach copy of report

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