

**University of South Dakota School of Health Sciences
REQUIRED IMMUNIZATION FORM**

Name _____ Date of Birth _____ USD ID# _____

Program: Addiction Counseling and Prevention ; BCBA ; Dental Hygiene ; Health Sciences Major ; Medical Laboratory Science ; Nursing ; Occupational Therapy ; Physical Therapy ; Physician Assistant ; BS in Public Health ; Master of Public Health ; BS in 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.

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: ____/____/____

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:	1 st dose	Date: ____/____/____
(Heplisav-B requires only 2 doses)	2 nd dose	Date: ____/____/____ (1 month after 1 st dose)
	3 rd dose	Date: ____/____/____ (6 months after 1 st dose)

Secondary HBV series:	4 th dose	Date: ____/____/____
(only if no response to primary series)	5 th dose	Date: ____/____/____
(Heplisav-B requires only 2 doses)	6 th 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** QuantiFERON 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:
(Interferon Gamma Release Assay)

Date:____/____/____ *Attach copy of report*

Additional testing, if positive or indeterminate

QuantiFERON TB Gold or T-Spot:
(Interferon Gamma Release Assay)

Date:____/____/____ *Attach copy of report*

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

F. 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.

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: _____