University of South Dakota Health Sciences
REQUIRED IMMUNIZATION FORM

Name **DOB** USD ID#

Program: Addiction Studies [ ] Dental Hygiene [ ] Health Science [ ] Medical Laboratory Science [ ] Medicine [ ] Nursing [ ] Occupational Therapy [ ] Physical Therapy [ ] Physician Assistant [ ] Public Health [ ] Social Work [ ] Master of Social Work [ ] Health Science Major Paramedic Specialization [ ]

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.

1 **Measles** (Rubeola)

Vaccine Dates: 1.____/_____/_____ 2._____/_____/_____
OR
Has report of positive immune titer. Date:____/_____/_____ **ATTACH LAB REPORT**

2 **Rubella** (German Measles)

Vaccine Dates: 1.____/_____/_____ 2._____/_____/_____
OR
Has report of positive immune titer. Date:____/_____/_____ **ATTACH LAB REPORT**

3 **Mumps**

Vaccine Dates: 1.____/_____/_____ 2._____/_____/_____
OR
Has report of positive immune titer. Date:_____/_____/_____ **ATTACH LAB REPORT**

B. **Date of Tdap (tetanus, 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** - Three doses and positive titer required.*(If unable to obtain dates of immunizations a positive titer is acceptable*)

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 – hepatitis B surface antibodies)

Immunity demonstrated by hepatitis B titer - **ATTACH LAB REPORT**

Date:_____/_____/_____ Positive/Reactive____ Negative/Nonreactive____

(if neg. see immunization policy)

Updated 3/23/2018

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E. **Tuberculosis Skin Test** - PPD (Mantoux) – Two-step TB skin test required initially or Interferon Gamma Release Assay

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 classes, an annual TB skin test is required

Date placed _____/_____/_____ Date read _____/_____/_____ Results:_____mm

Date placed _____/_____/_____ Date read _____/_____/_____ Results:_____mm

Interferon Gamma Release Assay (IGRA): Date:_____/_____/_____ Positive_____ Negative_____
ATTACH LAB REPORT

History of Positive TB Skin Test:

Date placed _____/_____/_____ Date read _____/_____/_____ Results:_____mm

ATTACH COPY OF CHEST X-RAY REPORT AND DOCUMENTATION FROM HEALTHCARE PROVIDER.

See immunization policy.

History of BCG vaccination: Date _____/_____/_____ (TB skin test required regardless of prior BCG vaccination)

F. **Influenza vaccine.** Required by Dec. 1st annually Date:_____/_____/_____
Not required prior to admission if starting in the summer or fall

RECOMMENDED IMMUNIZATIONS:

G. **Meningococcal Vaccine (Meningitis vaccine)**. Meningococcal Vaccine (Meningitis vaccine). Refer to immunization policy. Students should consult with their physician about their specific risk:

Vaccine:_____Date:_____/_____/_____ Vaccine:_____Date:_____/_____/_____

H. **Childhood DTP/TDaP/DPT immunizations:**

Dates of Primary Series: 1.____/_____/_____ 2._____/_____/_____ 3._____/_____/_____

4.____/_____/_____ 5._____/_____/_____

I. **Polio immunizations:**

Dates of Primary Series: 1.____/_____/_____ 2._____/_____/_____ 3._____/_____/_____

4.____/_____/_____ 5._____/_____/_____ Type of vaccine: Oral (OPV)_____ Inactivated (IPV)_____

SIGNATURE X _____ **Date _____/_____/_____**

Must be signed by Healthcare Provider (Physician, PA, NP, Nurse)

PRINT NAME _____

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

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A copy of titer/lab reports must be provided with this form as indicated above. *Updated 3/23/2018*