

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)

University of South Dakota Health Sciences  
REQUIRED IMMUNIZATION FORM

Name \_\_\_\_\_ DOB \_\_\_\_\_ USD ID# \_\_\_\_\_

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 # \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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