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)

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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