
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 (Rubella)**
      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 ofTdap (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 8/7/2018
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 Nov. 1st annually Date:_/__/___

Not required prior to admission if starting in the summer or fall

RECOMMENDED IMMUNIZATIONS:

G. **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.

Updated 8/7/2018