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.

REQUITRED 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 # ________________________________

____________________________________________________________

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