University of South Dakota Health Sciences
REQUIRED IMMUNIZATION FORM

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
# REQUIRED IMMUNIZATION FORM

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<th>Name</th>
<th>DOB</th>
<th>USD ID#</th>
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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) ____/____/____  (Date read) ____/____/____  Results: __________mm
- **Step 2** (Date placed) ____/____/____  (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*

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SUBMIT FORM TO: USD Student Health Services, Sanford Vermillion Clinic, Attn: Patty Waage, 20 S. Plum Street, Vermillion, SD 57069