University of South Dakota Health Sciences
REQUIRED IMMUNIZATION FORM

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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 Nov. 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 09/19/2019