

University of South Dakota
School of Health Sciences
REQUIRED IMMUNIZATION FORM

Name _____ Date of Birth _____ USD ID# _____
Street Address _____ City _____
State _____ Zip code _____

Program:

- | | |
|---|--|
| <input type="checkbox"/> Addiction Counseling and Prevention (B.S., M.A.) | <input type="checkbox"/> Nursing (B.S.N.; M.S.N.; D.N.A.P.; D.N.P) |
| <input type="checkbox"/> ABA Certificate | <input type="checkbox"/> Occupational Therapy (O.T.D.) |
| <input type="checkbox"/> Clinical Research Coordinator Certificate | <input type="checkbox"/> Physical Therapy (D.P.T.) |
| <input type="checkbox"/> Dental Hygiene (B.S.) | <input type="checkbox"/> Physician Assistant (M.S.) |
| <input type="checkbox"/> Health Sciences (B.S.; M.S.) | <input type="checkbox"/> Public Health (B.S.; M.P.H.) |
| <input type="checkbox"/> Medical Laboratory Science (B.S.) | <input type="checkbox"/> Social Work (B.S.; M.S.W.) |

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.

a. Measles (Rubeola)

Vaccine dates: 1. ____/____/____ 2. ____/____/____

OR

Has report of positive immune titer. Date: ____/____/____ **Attach lab report**

b. Rubella (German Measles)

Vaccine dates: 1. ____/____/____ 2. ____/____/____

OR

Has report of positive immune titer. Date: ____/____/____ **Attach lab report**

c. Mumps

Vaccine dates: 1. ____/____/____ 2. ____/____/____

OR

Has report of positive immune titer. Date: ____/____/____ **Attach lab report**

B. Tetanus, diphtheria, adult pertussis:

If longer than 10 years, date of latest booster:

Date: ____/____/____

Date: ____/____/____

Student's Name

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: 3 doses of Engerix-B, Recombivax, or Twinnix or 2 doses of Heplisav-B followed by a QUANTITATIVE Hepatitis B Surface Antibody (titer) preferably drawn 4-8 weeks after last dose. If negative, give a 4th dose and repeat titer in 4-8 weeks. If negative, complete the remainder of the second series followed by another titer drawn 4-8 weeks after the last dose of the second series. If Hepatitis B Surface Antibody is still negative after a secondary series, additional testing including Hepatitis B Surface Antigen should be performed.

Series received (mark one): _____ Engerix-B, Recombivax, or Twinnix (3 doses required)
_____ Heplisav-B (2 doses required)

Primary HBV series: 1st dose Date: ____/____/____
2nd dose Date: ____/____/____ (1 month after 1st dose)
3rd dose Date: ____/____/____ (6 months after 1st dose)

Secondary HBV series: 4th dose Date: ____/____/____
(only if no response to primary series) 5th dose Date: ____/____/____
6th dose Date: ____/____/____

AND

Hepatitis B Surface Antibody (titer)

Quantitative immunity demonstrated by Hepatitis B titer - **attach copy of titer report.**

**If negative/nonreactive, see immunization policy*

Date: ____/____/____ Positive/Reactive _____ Negative/Nonreactive _____

Date: ____/____/____ Positive/Reactive _____ Negative/Nonreactive _____

D. Tuberculosis Test: Two-step TB skin test required initially **or** QuantiFERON TB Gold Blood Test.

Two-Step TB Skin Test need to be completed 1-3 weeks apart. **Note:* any two documented TB skin tests completed within a 12-month period shall be considered a two-step if tests are completed 1-3 weeks apart.

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 class, one TB skin test within the past 12 months is required.

(Date placed) ____/____/____ (Date read) ____/____/____ Results: ____ mm

OR

QuantiFERON TB Gold or T-Spot: Date: ____/____/____ **Attach copy of report**
(Interferon Gamma Release Assay)

Student's Name _____

Additional testing, if positive or indeterminate

QuantiFERON TB Gold or T-Spot: Date: ____/____/____ Attach copy of report
(Interferon Gamma Release Assay)

History of Positive TB Skin Test: Date ____/____/____ Documentation of chest x-ray & treatment/duration required.

E. Influenza vaccine- Required annually by October 15. (Not required prior to admission if starting in the summer or fall semester.) Date: ____/____/____

RECOMMENDED IMMUNIZATIONS:

Covid-19 Vaccine. Highly recommended for all students.

Manufacturer _____

Date ____/____/____ Date ____/____/____ Date ____/____/____

Meningococcal Vaccine (Meningitis vaccine). Recommended for students living in college dormitories who have not been immunized previously or for college students under 25 years of age who wish to reduce their risk. Date: ____/____/____

SIGNATURE: _____ Date: _____

*Must be signed by **Healthcare Provider (Physician, PA, NP, Nurse)***

PRINT NAME: _____ Title: _____

Hospital/Clinic Address of individual verifying this information:

Telephone number of hospital/clinic: _____

Email contact: _____