REQUIRED IMMUNIZATION FORM

PLEASE RETURN TO YOUR HOME UNIVERSITY

University of South Dakota Sanford Clinic Vermillion Student Health Service 20 S Plum St Vermillion, SD 57069 Phone: 605-638-8279 Fax: 605-624-6636	**South Dakota State University** Student Health Service Box 2818, Wellness Center North Campus Drive Brookings, SD 57007 Phone: 605-688-4157 Fax: 605-688-4032	**Dakota State University** Student Health Service 820 N Washington Madison, SD 57042 Phone: 1-888-378-9988 Fax: 605-256-5020	**Northern State University** Student Health Center 1200 S Jay Street Aberdeen, SD 57401 Phone: 605-626-7694 Fax: 605-626-3399

IMMUNIZATION REQUIREMENTS FOR REGISTRATION

Due to regulations mandated by the Board of Regents, ALL students, whatever their classification or status, must document their immune status for measles, mumps and rubella (MMR). Proof of two doses of the MMR vaccine; OR two doses of measles, mumps and rubella vaccine; OR the presence of immune antibody titers for measles, mumps and rubella shall be required. Immunization forms are available at University Center. Students who fail to provide the required, signed proof of immunization, or file an exemption for religious or medical reasons, shall not be permitted to register for or to attend classes at any state institution until in compliance. Students born before January 1, 1957 are exempt from providing immunization documentation. If documentation is not presented at the time of registration or already on file, you will not be registered until the documentation is provided. If you don't know if your MMR documentation is already on file, please call (605) 367 -5640 to verify this information.

IMMUNIZATION RECORD

Name ______________________________ Birthdate ____/____/____ Soc Sec # ____/____/____
Last First Middle

Address ____
Street City State Zip

First Immunization
Administered on 1st birthday or later.
Immunization prior to 1st birthday is not acceptable)

MMR (MR) _______/_____/_____ (month day year)

Second Immunization
Administered 30 days or more after the first immunization.

MMR (MR2) _______/_____/_____ (month day year)

OR

Measles (Rubeola) (RO) (Red Measles) _______/_____/_____ (month day year)

Rubella (RU) (German measles) _______/_____/_____ (month day year)

Mumps (MU) _______/_____/_____ (month day year)

Measles (Rubeola) (RO2) _______/_____/_____ (month day year)

Rubella (RU2) _______/_____/_____ (month day year)

Mumps (MU2) _______/_____/_____ (month day year)

OR

Rubeola Titer (ROT); Positive Results Date _______/_____/_____ (Please attach lab results)
OR ____ Had disease, confirmed by office record; Date _______/_____/_____
Rubella Titer (RUT); Positive Results Date _______/_____/_____ (Please attach lab results)
OR ____ Had disease, confirmed by office record; Date _______/_____/_____
Mumps Titer (MUT); Positive Results Date _______/_____/_____ (Please attach lab results)
OR ____ Had disease, confirmed by office record; Date _______/_____/_____

Signature ______________________________ Date _______/_____/_____
(Must be signed by Physician or Nurse)

OVER

MEDICAL EXCEPTION TO IMMUNIZATION REQUIREMENT

The physical condition of the above named student is such that the required immunizations would endanger life or health.

Reason for exemption: ____

Check one: _____ Permanent _____ Temporary (date to be released ______/_____/_____)

Signature of Physician ____ Date ______/_____/_____

RECOMMENDED IMMUNIZATIONS (Not required for registration)

Name ____
Last First Middle

Check appropriate line(s)			MONTH / DAY / YEAR
Tetanus-Diphtheria	_____	Completed primary series of tetanus-diphtheria immunization	______ / ______ / ______
	_____	Received tetanus-diphtheria booster within the last 10 years	______ / ______ / ______
Polio	_____	Completed primary series of polio immunizations	______ / ______ / ______
		Type of vaccine: _____ OPV _____ IPV	
		Date of last booster	______ / ______ / ______
Tuberculosis	_____	PPD (Mantoux) test within the past year	______ / ______ / ______
		Results of test ____________________	

Immunization for Hepatitis B, Poliomyelitis, Varicella and Meningitis are also recommended.

Hepatitis B	_____	______ / ______ / ______
		______ / ______ / ______
		______ / ______ / ______
Poliomyelitis	_____	______ / ______ / ______
Varicella	_____	______ / ______ / ______
		______ / ______ / ______
Meningitis	_____	______ / ______ / ______