REQUIRED IMMUNIZATION FORM

IMMUNIZATION REQUIREMENTS FOR REGISTRATION

Due to regulations mandated by the Board of Regents, all students, who reside on campus or receive instruction on campus, must document their immune status for measles, mumps and rubella. **"Proof of <u>two doses</u> of measles, mumps and rubella vaccine**, or of separate vaccinations against all three diseases, or of the presence of immune antibody titers against measles, mumps and rubella shall be required." Students who fail to provide the required, signed proof of immunization shall not be permitted to register for or to attend classes at any state institution until they are in compliance. Students born before January 1957 are exempt from providing immunization documentation.

Name _____ Birth Date _____ / _____ / _____
Last First Middle Month Date Year

Soc. Sec. # _____/_____/_____ Phone (____)_____ Cell (____)_____

Address _____
Street City State Zip Code

<u>REQUIRED IMMUNIZATIONS</u> - Must be filled out and signed (below) by a Health Care Provider

Date of 1st Measles, Mumps, Rubella Immunization
(Must be given after age 12 months)

Date of 2nd Measles, Mumps, Rubella Immunization
(Must be given at least 30 days after 1st MMR)

#1 MMR_____/_____/_____ AND #2 MMR _____ / _____ / _____

OR Separate Immunizations:

#1 Rubella_____/_____/_____ AND #2 Rubella_____/_____/_____

#1 Rubeola _____/_____/_____ AND #2 Rubeola _____/_____/_____

#1 Mumps_____/_____/_____ AND #3 Mumps _____/_____/_____

OR Titers

Rubella Titer Date _____ / _____ / _____ POSTIVE Result _____Attach copy of Lab result

Rubeola Titer Date_____ / _____ / _____ POSITIVE Result_____Attach copy of Lab result

Mumps Titer Date _____ / _____ / _____ POSITIVE Result _____Attach copy of Lab result

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Printed Physician Name: _____

Signature _____ Date _____
(Must be signed by a Nurse, P.A. or Physician

Clinic Name _____

RETURN THIS FORM TO DSU ENROLLMENT SERVICES

Heston Hall, 820 N. Washington Ave, Madison SD 57042 or FAX: 605-256-5020

REQUIRED IMMUNIZATION FORM

MEDICAL EXEMPTION TO IMMUNIZATION REQUIREMENT

I certify that it would be harmful to this student's physical health to be immunized against measles, mumps, and rubella.

Reason for Exemption: _____

Check one: _____ Permanent Exemption

_____ Temporary Exemption - Date to be released: _____
Month Day Year

Printed Physician Name: _____

Signature _____ Date _____
(Must be signed by a Physician)

Clinic Name _____

RECOMMENDED IMMUNIZATIONS (Not required for registration)

Name: _____
Last First Middle

Tetanus-Diphtheria (Td) booster _____/_____/_____ or Tdap _____ / _____ /_____

Hepatitis B 1. _____ /_____ /_____ 2. _____/ _____ / _____ 3. _____/ _____/ _____

Meningitis _____ / _____ / _____

Varicella (Chicken Pox) Vaccine 1. _____/_____ / _____ 2. _____ / _____ /_____
OR
Chicken Pox Disease (Date) _____/_____ / _____

Tuberculosis - PPD (Mantoux) within the last year _____/ _____ /_____ Results: _____