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 two doses 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

Phone (____) __________________ Cell (____) __________________________

Address __________________________

Street City State Zip Code

REQUIRED IMMUNIZATIONS - 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 ________ / _______ / _______ POSITIVE 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

Physician Name (please print): ________________________________

Signature ____________________________ Date __________________________

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

Clinic Name ________________________________

RETURN THIS FORM TO DSU ADMISSIONS - Heston Hall, 820 N. Washington Ave, Madison SD 57042
or FAX: 605-256-5020
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: ____________