

IMMUNIZATION REQUIREMENTS FOR REGISTRATION

Due to regulations mandated by the State of South Dakota, ALL students entering a post-secondary institution for the first time after July 1, 2008, 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. Students who fail to provide the required, signed proof of immunization, or file an exemption for religious or medical reasons, within 45 days from the beginning of the semester shall not be permitted to continue to attend classes until in compliance. Students born before January 1, 1957 are exempt from providing immunization documentation. Please submit the form below or a record generated by your physician or clinic to the Admissions Office.

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 (Rubeloa) (RO) ____/____/____
(Red Measles) month day year

Measles (Rubeola) (RO2) ____/____/____
month day year

Rubella (RU) ____/____/____
(German measles) month day year

Rubella (RU2) ____/____/____
month day year

Mumps (MU) ____/____/____
month day year

Mumps (MU2) ____/____/____
month day year

OR

Rubeloa 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)

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 ____/____/____
