SINTE GLESKA UNIVERSITY

PO BOX 105
ROSEBUD SIOUX RESERVATION
MISSION, SD 57555-0105
TELEPHONE (605) 856-8100

ACCREDITED BY
THE NORTH CENTRAL ASSOCIATION
OF COLLEGES AND SCHOOLS 1983

CHARTERED BY THE ROSEBUD SIOUX TRIBE 1971

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). Check all that apply:
Vaccine Dates: 1.____/_____/_____ 2._____/_____/_____
Has report of positive immune titer. Date:____/_____/_____ *attach copy of titer report*
b. **Rubella** (German Measles) Clinical history is not acceptable. Check all that apply.
Vaccine Dates: 1.____/_____/_____ 2._____/_____/_____
Has report of positive immune titer. Date:____/_____/_____ *attach copy of titer report*
c. **Mumps** Check all that apply.
Vaccine Dates: 1.____/_____/_____ 2._____/_____/_____
Has report of positive immune titer. Date:_____/_____/_____ *attach copy of titer report*
B. **Diphtheria-Tetanus-Pertussis**
Dates of primary series: 1._____/_____/_____ 2._____/_____/_____ 3._____/_____/_____
4._____/_____/_____ 5._____/_____/_____
Date of last booster within the last 10 years. Td, TT, or Tdap (*circle one*): Date:_____/_____/_____
C. **Polio**
Dates of primary series: 1._____/_____/_____ 2._____/_____/_____ 3._____/_____/_____
4._____/_____/_____ Type of vaccine: Oral (OPV)_____ Inactivated (IPV)_____
Booster **(optional):** Date:_____/_____/_____; Type of vaccine: Oral (OPV)_____ Inactivated (IPV)_____
D. **Varicella** (Chicken Pox) One of the following is required:
Documentation of positive varicella titer. Date:_____/_____/_____ *attach copy of titer report*
(if negative, varicella immunization required)
OR
Vaccine: One dose of vaccine is required if given prior to age 13. Two doses are required if given after age 13.
Dates: 1._____/_____/_____ 2._____/_____/_____

Name_____ **Appendix D**

E. **Hepatitis B Vaccine -** Three doses and positive titer required.

Name and Address of where immunization was obtained:

1st dose Date:_____/_____/_____ _____

2nd dose Date:_____/_____/_____(1 month after 1st dose) _____

3rd dose Date:_____/_____/_____ (6 months after 1st dose) _____

AND

Hepatitis B Titer (HbsAB or Anti-HBs – antibody to hepatitis B surface antigen)

Immunity demonstrated by hepatitis B titer - *attach copy of titer report.*

Date:_____/_____/_____ Positive/Reactive_____ Negative/Nonreactive_____ (if neg. see immunization policy)

F. **Tuberculosis Skin Test -** PPD (Mantoux) – Two-step TB skin test required initially and annual TB skin test thereafter.

Two-Step TB Skin Test

Step 1 (Date placed) _____/_____/_____ Step 1 (Date read) _____/_____/_____ Results:_____mm

Step 2 (Date placed) _____/_____/_____ Step 2 (Date read) _____/_____/_____ Results:_____mm

*Note any two documented TB skin tests completed within a 12 month period shall be considered a two-step.

Annual TB Skin Test

If two-step was completed more than 12 months prior to start of class, one TB skin test within the past 12 months are required.

Date placed _____/_____/_____ Date read _____/_____/_____ Results:_____mm

History of Positive TB Skin Test**:** Date _____/_____/_____

Documentation of chest x-ray & treatment required.

History of BCG vaccination: Date _____/_____/_____

TB skin test required regardless of prior BCG vaccination.

RECOMMENDED IMMUNIZATIONS:

Meningococcal Vaccine (Meningitis vaccine). Recommended for students living in college dormitories whom have not been immunized previously or for college students less than 25 years of age who wishes to reduce their risk.

Date:_____/_____/_____

Influenza vaccine. Recommended annually for healthcare providers.

Date:_____/_____/_____

A copy of titer reports (i.e. hepatitis B, varicella, mumps, rubella, rubeola) must be provided with this form as indicated above.

SIGNATURE _____

Date _____/_____/_____

Must be signed by ***Physician or Nurse***

PRINT NAME _____

Hospital/Clinic Address of physician or nurse verifying this information:

_____

_____

Telephone number of hospital/clinic: ( )_____