Required Immunization Health History Form

Name: _____ _____ _____ Date of Birth: ____ / ____ / ____
Last First Initial Month Day Year

Social Security Number: XXX - XX- _____ Student I.D. # _____ Phone: _____

E-mail Address: _____ @ _____

Address: _____ _____ _____ _____
Street City State Zip

1. Immunization Required for ALL Students Born after 01/01/1957 * Required by South Dakota State Law

1. MMR (Measles/Mumps/Rubella)
Dose: 1 ___ / ___ / ___ Dose: 2 ___ / ___ / ___
Month Day Year Month Day Year

2. Measles (Rubeola)
Dose: 1 ___ / ___ / ___ Dose: 2 ___ / ___ / ___
Mumps
Dose: 1 ___ / ___ / ___ Dose: 2 ___ / ___ / ___
Rubella
Dose: 1 ___ / ___ / ___ Dose: 2 ___ / ___ / ___
Month Day Year Month Day Year

OR

3. Lab titers showing immunity
***attach a copy of lab results**
Measles Titer/Date ___ / ___ / ___
MumpsTiter/Date ___ / ___ / ___
Rubella Titer/Date ___ / ___ / ___
Month Day Year

Recommended for ALL Students

Menactra or Menuomune (for Meningococcal Meningitis)
Dose: 1 ___ / ___ / ___ Dose: 2 ___ / ___ / ___ Declined Vaccination Date: ___ / ___ / ___
Month Day Year Month Day Year Month Day Year

Hepatitis B
Dose: 1 ___ / ___ / ___ Declined Vaccination Date: ___ / ___ / ___
Month Day Year Month Day Year
Dose: 2 ___ / ___ / ___
Month Day Year
Dose: 3 ___ / ___ / ___
Month Day Year

Recommended Test or Immunizations (not mandatory)

Tuberculosis Skin Test PPD (Mantoux)
Result: Neg ____ Pos ____ Date: ___ / ___ / ___ Chest Xray Result: Normal___ Abnormal ___ Date: ___ / ___ / ___
Month Day Year Month Day Year

Varicella (Chicken Pox)
History of Disease: ___ / ___ / ___ or Titer Date ___ / ___ / ___ OR Varivax Dose: 1 ___ / ___ / ___ Dose: 2 ___ / ___ / ___
Month Day Year Month Day Year Month Day Year Month Day Year

Tetanus/Diphtheria Date:___ / ___ / ___ Circle type of vaccination Td TDap
Month Day Year

2. Name of Clinic or Physician & Address *Copies of vaccination records accepted in place of signature if accompanied by this form

_____ _____ _____
Name of Clinic or Physician Physician or Authorized Signature Date

Address: _____ _____ _____ _____
Street City State Zip