Required Immunization Form

THIS FORM MUST BE RETURNED PRIOR TO REGISTRATION

Return to:
Student Health Services
Northern State University
1200 South Jay Street
Aberdeen, SD 57401

Contact:
FAX # 1-605-626-3399
PHONE # 1-605-626-2544
hlthser@northern.edu

NAME ______________________ BIRTHDATE __________ SOC SEC# XXX – XX - ______
Last First MI Month Day Year (Enter Last Four Digits)

ADDRESS ____
Street City State Zip Code

PHONE ____________________ **NOTE: Two (2) MMR's or Three (3) Titers are required**

Two (2) Measles, Mumps, and Rubella (MMR) immunizations **OR** immune titers (Rubeola, Mumps and Rubella) are required for college admission. **Vaccination information is to be completed and signed by a health care provider and/or attach a copy of your vaccination record to this form.**

Date of first Measles, Mumps, Rubella Immunization MMR 1 ________ / ________ / ________
Month Day Year

Date of second Measles, Mumps, Rubella Immunization MMR 2 ________ / ________ / ________
Month Day Year

OR TITERS

Blood test for proof of immunity to Measles (Rubeola), Mumps and Rubella – **ALL THREE REQUIRED!**
Attach proof of labs

Measles (Rubeola) Titer Results: ______________ Date ______________

Mumps Titer Results: ______________ Date ______________

Rubella Titer Results: ______________ Date ______________

If you have had the following immunizations, please indicate the dates for each:

MENINGITIS

Date ______________

HEPATITIS B SERIES

1st ______________

2nd ______________

3rd ______________

TETANUS / DIPHTHERIA (DTaP or Td)

Date ______________

Signature x ______________________ Date ______________

(Must be signed by the physician or nurse completing this form)

Clinic Stamp:
(Must Include - Name and Address of Clinic)

IMMUNIZATION EXEMPTIONS

1. Medical Exemption

I certify that it would be harmful to this student's health to be immunized against measles, mumps, and rubella. **(A permanent exemption may be issued only if the student suffers from a physical condition from which immunizations would endanger the student's life or health.) Reason must be listed here by physician and signed below by physician.**

Explain Reason for Exemption: ____

____

Check one:

_____ Permanent Exemption

_____ Temporary Exemption (Pregnancy, etc)

Date temporary exemption to be released ______________________
Month Day Year

Physician's Name Printed ____

Physician's signature ______________________________ Date: ______________
(**Must be signed by Physician**)

Clinic Stamp:
(Must Include - Name and Address of Clinic)

OR

2. My birthdate is prior to January 1, 1957

Date of Birth ____________________ Student's Signature x ______________________________
Month Day Year

If you have any questions regarding this requirement, please call.

PLEASE RETAIN A COPY OF THIS FORM FOR YOUR RECORDS