DAKOTA WESLEYAN UNIVERSITY

**REQUIRED**
**IMMUNIZATION FORM**
INTERNATIONAL STUDENTS

**REQUIRED to proceed with class registration at Dakota Wesleyan University. Please print.**

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

Home Address _____
Street Address City State Zip

Student's Email Address _____

**The information below MUST BE COMPLETED BY A HEALTHCARE PROVIDER. Copies of the complete vaccination record(s) must accompany this form. For more information on USA vaccination schedule, go to www.dwu.edu/USAimmunizations.**

# REQUIRED IMMUNIZATIONS

This form must be completed and signed by your healthcare provider.

## MMR required immunization for ALL students born after 01/01/1957 is required by South Dakota state law.

**1. MMR (Measles, Mumps, Rubella)** (2 doses required)

Dose No. 1: ____ / ____ / ____ Dose No. 2: ____ / ____ / ____ OR

*If given as separate doses, please identify:*

**2. Measles (Rubeola)**

Dose No. 1: ____ / ____ / ____ Dose No. 2: ____ / ____ / ____ OR

**Mumps**

Dose No. 1: ____ / ____ / ____ Dose No. 2: ____ / ____ / ____

**Rubella (German Measles)**

Dose No. 1: ____ / ____ / ____ Dose No. 2: ____ / ____ / ____

**3. Lab Titers Showing Immunity** (Attach a copy of all lab results.)

Measles Titer Date ____ / ____ / ____

Mumps Titer Date ____ / ____ / ____

Rubella Titer Date ____ / ____ / ____

**NOTE:** If born before 1957, you are considered immune and require no further vaccination.

## Tdap, Varicella and Hepatitis B (highly recommended for ALL incoming students; mandatory for nursing and athletic training majors)

**1. Tetanus/Diptheria/Pertussis**

Date Primary Series Completed: ____ / ____ / ____ Tdap Booster: ____ / ____ / ____

**2. Varicella – Chicken Pox**

Documented History of Disease: ❑ Yes ❑ No OR Varicella Titer Date: ____ / ____ / ____ (Attach a copy of titer lab result.) OR

Immunization: Varivax Dose No. 1: ____ / ____ / ____ Varivax Dose No. 2: ____ / ____ / ____

**3. Hepatitis B** (highly recommended for ALL; mandatory for nursing and athletic training majors – refer to immunization requirements for specific major)

Dose No. 1: ____ / ____ / ____ Dose No. 2: ____ / ____ / ____ Dose No. 3: ____ / ____ / ____

**4. Meningitis**

Meningococcal Immunization: VACCINE OR DECLINATION SIGNATURE REQUIRED
Please read the following information at **www.dwu.edu/meningitis** and consult with your healthcare provider.

MenACWY Vaccines (Menactra or Menveo)

Dose No. 1: ____ / ____ / ____ Dose No. 2 (Booster): ____ / ____ / ____

I have received information about meningococcal disease and choose **NOT** to receive the vaccine at this time.

_____ _____
Signature required if **NOT** receiving the vaccine. Date

**5. Serogroup B Meningococcal: MenB-4C (Bexsero) OR MenB-FHbp (Trumenba)**

Dose No. 1: ____ / ____ / ____ Dose No. 2: ____ / ____ / ____

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**6. Hepatitis A** (required for travel outside of the United States of America for mission or service-learning trips)

Dose No. 1: _____ / _____ / _____ Dose No. 2: _____ / _____ / _____

**7. Quadrivalent Human Papilloma Vaccine (HPV)** (Protects against cervical, anal and other cancers, as well as genital warts.)

Dose No. 1: _____ / _____ / _____ Dose No. 2: _____ / _____ / _____ Dose No. 3: _____ / _____ / _____

**8. COVID-19 History**

1. If diagnosed with COVID-19 in the last 90 days, submit a copy of the positive lab result with your name on the document.
2. If vaccinated: Name of serum administered: _____

   Dose No. 1: _____ / _____ / _____ Dose No. 2: _____ / _____ / _____ Booster, if applicable: _____
3. ❑ Check box if you elect NOT to vaccinate for COVID-19.

**Tuberculosis (TB) Screening**

Answer the following questions.

1. Have you ever been vaccinated with BCG (Bacillus Calmette Guerin)? ❑ Yes ❑ No
2. Are you from or have you ever lived for two months or more in Asia, Africa, Central or South America, or Eastern Europe? ❑ Yes ❑ No
3. Have you ever had close contact with anyone who was sick with TB? ❑ Yes ❑ No
4. Have you ever had a **positive** TB skin test? ❑ Yes ❑ No *If "**NO**," disregard chest X-ray question.*

   Chest X-ray Result: ❑ Normal ❑ Abnormal Date of Chest X-ray: _____ / _____ / _____ (Attach a copy of X-ray report.)

**Tuberculosis (TB) Testing**

If you answer **"YES"** to any of the four questions above, Dakota Wesleyan University requires that a healthcare provider complete a tuberculosis test within six months before the start of classes. All costs associated with the assessment shall be the responsibility of the student. Consult your medical provider for appropriate test.

**Submit results of one of the following:**

**A.** A two-step Mantoux Tuberculin Skin Test (two tests on two different arms, separated by 1 to 4 weeks) **OR**

**B.** A QuantiFERON Test (blood draw) **OR**

**C.** A T-spot Test

_____ _____

Physician's/Heathcare Provider's Signature Date

_____

**PLEASE PRINT:** Healthcare Provider's Name

_____

Healthcare Provider's Street Address City State Zip Phone No.

## Mail Completed Form to:

Dakota Wesleyan University Health Services
1200 W. University Ave., Box 926
Mitchell, SD 57301

Scan and email in PDF format to **Donna.Gerlach@dwu.edu** or fax to **605-995-2892**.