DAKOTA WESLEYAN UNIVERSITY

REQUIRED
IMMUNIZATION FORM
AMERICAN 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) are accepted in place of signature if accompanied by 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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NAME: _____

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

_____ Date _____

Physician's/Heathcare Provider's Signature

_____

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**.