# REQUIRED IMMUNIZATION FORM

**Prior to registration please return to:**

**Student Health Service**
South Dakota School of Mines & Technology
501 E. Saint Joseph Street
Rapid City, SD 57701-3995

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**IMMUNIZATION REQUIREMENTS FOR REGISTRATION**
Due to regulations mandated by the South Dakota Board of Regents and the State Health Department, medically signed proof of **TWO** properly administered immunizations **OR** immune titers for Measles (Rubeola) and Rubella are now required for all new, readmit and transfer students at all State Institutions born after December 31, 1956. It is highly recommended to receive a Meningococcal Vaccine.

If you have only one immunization, the required second immunization may be administered not less than one month after the first immunization. Students who fail to provide the required proof of immunization will be **REFUSED REGISTRATION** until in compliance.
Upon completion of the immunization requirements, return this form to Student Health Service at the above address.

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Name_______________________________________________ Birth date_____/_____/_____
Last First Middle mm dd yy

Address_______________________________________________
Street City State Zip Code

Soc. Sec.: ______-______-______ Marital Status: _____Married ______Single Sex: ___ Male___ Female

Next of Kin_______________________________________________ Phone (____)__________

Address_______________________________________________
Street City State Zip Code

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**IMMUNIZATION RECORD**

| **First Immunization**<br>**Administered on 1st birthday or later**<br>**(Immunization prior to 1st birthday is not acceptable.)** | Month / Day / Year | **Second Immunization**<br>**Administered 30 days or more after the first immunization.** | Month / Day / Year |
|---|---|---|---|
| MMR | ____/____/____ | MMR | ____/____/____ |
| Measles (Rubeola) | ____/____/____ | Measles (Rubeola) | ____/____/____ |
| Rubella | ____/____/____ | Rubella | ____/____/____ |

**OR**

Mumps Titer; Results:______________________ Date ____/____/____

Rubeola Titer; Results:______________________ Date ____/____/____

Rubella Titer; Results:______________________ Date ____/____/____

Meningococcal Vaccine (Date) ________________

Signature_______________________________________ Date ____/____/____
(Must be signed by Physician or Nurse)

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**MEDICAL EXEMPTION TO IMMUNIZATION REQUIREMENT**
The physical condition of the above named student is such that the required immunizations would endanger life or health.
Reason for exemption:_______________________________________
Check one: ______Permanent ______Temporary (Date to be released________________)

Signature of Physician_______________________________________ Date ____/____/____

7/13/2007