IMMUNIZATION FORM

Prior to registration return to:

Dean of Students Office
Surbeck Center
South Dakota School of Mines & Technology
501 E. Saint Joseph Street
Rapid City, SD 57701-3995
FAX: 605-394-2914 PHONE: 605-394-2416

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 January 1, 1957. Although not required, the Meningococcal Vaccination is strongly encouraged.

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 Students who fail to provide the required proof of immunization will be **REFUSED REGISTRATION and WITHDRAWN FROM CLASSES** until in compliance. **Upon completion of the immunization requirements, return this form to the Dean of Students Office - see the above contact information.**

Name: _____ Birth date_____/_____/_____
Last First Middle mm dd yy

Address: _____
Street City State Zip Code

Sex: ___ Male___ Female Cell Phone: (___)_____ Home Phone:(___)_____

Student ID (if known) _____ Closest Relative:_____

Address_____
Street City State Zip Code

IMMUNIZATION RECORD

First Immunization
Administered on 1st birthday or later
(Immunization prior to 1st birthday is not acceptable.)

	Month	Day	Year
MMR	_____	_____	_____
Measles (Rubeola)	_____	_____	_____
Rubella	_____	_____	_____

Second Immunization
Administered 30 days or more after the first immunization.

	Month	Day	Year
MMR	_____	_____	_____
Measles (Rubeola)	_____	_____	_____
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)

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 _____/_____/_____

10/9/2013