

AUGUSTANA UNIVERSITY

CAMPUS CLINIC

IMMUNIZATION RECORD

Augustana University **requires** all students to complete the Student Health Record (online) and Immunization Record as a condition of enrollment.

Return this form with physician signature or supporting documentation to:
Campus Clinic, 2001 S Summit Ave. Box 771, Augustana University, Sioux Falls, SD 57197,
FAX to 605.274.4901, or Email to goodhealth@augie.edu

Student ID#: _____ Name: _____ Birthdate: _____
(Last) (First) (Middle)

Home Address _____ City or Town _____ State _____ Zip _____ Country _____ Mobile Phone # _____

The South Dakota State Health Department requires ALL students whatever their classification or status, to have medically signed proof of TWO properly administered immunizations OR immune titers for Measles (Rubeola), Rubella and Mumps (MMR) and *current MENINGOCOCCAL (Meningitis). These are required for all new, readmitted and transferred students of all public or private postsecondary educational institutions.

UNIVERSITY REQUIRED IMMUNIZATIONS (OR EXEMPTION FORM)

MMR (Two doses required) _____ / _____ / _____ (1 mo) _____ / _____ / _____
(Measles, Mumps, Rubella) MO DAY YR MO DAY YR

MENINGOCOCCAL (Meningitis) _____ / _____ / _____
(*at or after age 16 to be current) MO DAY YR

Copies of vaccination records accepted in place of signature if accompanied by this form

Name of Clinic or Physician Physician or Authorized Signature Date

Clinic Address City State Zip

UNIVERSITY RECOMMENDED IMMUNIZATIONS

Hepatitis B (Three doses required) _____ / _____ / _____ (1mo) _____ / _____ / _____ (5mo) _____ / _____ / _____
MO DAY YR MO DAY YR MO DAY YR

Hepatitis A (Two doses required) _____ / _____ / _____
MO DAY YR MO DAY YR

Polio (Last date) _____ / _____ / _____
MO DAY YR

Tetanus-Diphtheria (Every 10 years) _____ / _____ / _____
MO DAY YR

PPD (Tuberculin) _____ / _____ / _____
MO DAY YR

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EXEMPTION REQUEST FOR IMMUNIZATION REQUIREMENT

Student ID#: _____ Name: _____ Birthdate: _____
(Last) (First) (Middle)

Home Address _____ City or Town _____ State _____ Zip _____ Country _____ Mobile Phone # _____

Students who apply for exemption are encouraged to discuss the risks of non-compliance with their health care providers. By requesting the exemption to immunization requirements, the student may be excluded from university activities, including classes, in the event that the South Dakota Department of Health declares the existence of a measles, mumps, rubella, or meningococcal outbreak at Augustana University. An exclusion shall remain in effect for such time as determined by the South Dakota Department of Health.

Medical Exemption: The physical condition of the above named student is such that the required MMR & Meningococcal Immunizations would endanger life or health.

Signature of Medical Professional (Required) DATE

Printed Name

Conscientious/Religious Exemption (Must be notarized): Must complete if unable to meet required immunizations due to conscientious or religious belief. *I hereby certify by notarization that my conscientious or religious belief is opposed to immunizations.*

Signature of student (Parent/guardian of student, if minor) DATE

Subscribed and sworn to me on the ____ day of _____, 20__

Signature of Notary: _____ Expiration _____