AUGUSTANA UNIVERSITY

CAMPUS CLINIC

IMMUNIZATION RECORD

Augustana University **requires** all students to complete the Immunization Record as a condition of enrollment.

Return this form with physician signature or the medical documentation of the vaccines via email goodhealth@augie.edu or deanofstudents@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). 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) (Measles, Mumps, Rubella) _____/_____/_____ (1 mo) MO DAY YR _____/_____/_____ MO DAY YR

Copies of vaccination records accepted instead of the physician's signature if accompanied by this form

_____ _____ _____
Name of Clinic or Physician Physician or Authorized Signature Date

_____
Clinic Address City State Zip

UNIVERSITY RECOMMENDED IMMUNIZATIONS

COVID One or Two doses _____/_____/_____ MO DAY YR _____/_____/_____ MO DAY YR Type:_____ Pfizer or Moderna or Johnson & Johnson

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

Hepatitis A -Two doses _____/_____/_____ 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

Meningococcal *(Meningitis)* - Two doses with the last one after the age of 16 _____/_____/_____ MO DAY YR _____/_____/_____ MO DAY YR

Meningococcal B *(Meningitis B)* - Two doses after the age of 16 _____/_____/_____ MO DAY YR _____/_____/_____ MO DAY YR

AUGUSTANA UNIVERSITY

CAMPUS CLINIC

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 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 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 _____