MOUNT MARTY COLLEGE

Nursing Program Required Immunization Health History Form
Required for students to proceed with class registration at MMC.
Please Print.

Name: _____ _____ _____ Date of Birth: ____/____/____
Last First Initial M D Y

Student I.D. # _____ Phone: _____

Address: _____ _____ _____ _____
Street City State Zip

A. Immunizations Required

1. MMR (Measles/Mumps/Rubella) for ALL Students Born after 12/31/1956

*Two doses required at least 28 days apart for students born after 1956.

Dose1:___/___/____ Dose2: ___/___/____
M D Y M D Y

*Dose 1 given at age 12 months or later. Dose 2 given at least 28 days after first dose.

2. Measles (Rubeola)

Dose1: ___/___/____ Dose2: ___/___/____ **OR** Measles Titer/Date ___/___/____ Results:_____
M D Y M D Y M D Y

Mumps

Dose1: ___/____/____ Dose2: ___/___/____ **OR** Mumps Titer/Date___/____/____ Results:_____
M D Y M D Y M D Y

Rubella

Dose1: ___/____/____ Dose2: ___/___/____ **OR** Rubella Titer/Date___/____/____ Results:_____
M D Y M D Y M D Y

3. Hepatitis B

Dose1: ___/___/____ **Hepatitis B Surface Antibody** ___/___/____

Dose2: ___/___/____ Result: Reactive_____ Nonreactive_____

Dose3: ___/___/____ _____ MIU/ml
M D Y

4. Varicella (Chicken Pox)

Varivax Dose1: __/__/___ Dose2: __/__/__ **OR** Titer Date__/__/____ Results_____
M D Y M D Y

5. Tdap Date: ___/___/___ (Required one time dose)**Tetanus/ Diphtheria** Date: __/__/____ (every 10 years)
M D Y M D Y

6. Annual Tuberculosis Skin Test PPD (Mantoux)

Date given: ___/___/___ Date Read: ___/___/___ Result: ____mm induration
M D Y M D Y If positive: Chest Xray Result: Normal___Abnormal___Date:__/__/___
M D Y

Has received the **BCG vaccine** Date: ___/___/____ ____Medical Exempt Waiver Signed
M D Y

____For history of positive PPD, annual signs and symptoms evaluation complete: Date: ___/___/____
M D Y

7. **Annual Influenza**

Date of last dose: ___/___/____ _____Medical/Religious Exempt Waiver Signed Date: ___/___/____
M D Y M D Y

Inactivated influenza vaccine _____ Live attenuated influenza vaccine (LAIV)_____

8. Menactra or Menuomune (for Meningococcal Meningitis)

Dose1: ___/___/____ Dose2: ___/___/____ Declined Vaccination Form Signed/Date: ___/___/____
M D Y M D Y M D Y

B. Miscellaneous Immunization Information (if applicable)

1. Polio (Recommended)

(Primary series, doses at least 28 days apart. Three primary series are acceptable. See ACIP website for details.)

1. OPV alone: #1__/___/____ #2___/___/____ #3___/___/_____
M D Y M D Y M D Y

2. IPV/OPV Sequential: IPV #1 ___/___/____ IPV #2___/___/____ OPV #3___/___/____ OPV #4__/___/____
M D Y M D Y M D Y M D Y

3. IPV alone: #1__/___/____ #2 __/__/____ #3 ___/__/____ #4 __/___/____
M D Y M D Y M D Y M D Y

C. Other Immunizations: Please list other immunizations here:

Name of Clinic or Physician and Address
***Signed copies of vaccination record accepted in place of signature if accompanied by this form.**

_____ _____ _____
Name of Clinic or Physician | Physician/CNP/PA-C Signature | Date

Address: _____ _____ _____ _____
Street | City | State | Zip

Mail, Fax or e-mail the form to Mount Marty College 1105 W 8th Street Yankton, SD 57078
Fax: 605-668-1524 Attention Student Health Services
E-Mail to Susan Thorson at sthorson@mtmc.edu

References: www.cdc.gov, American College Health Association, MMWR June 14, 2013 VOL 62(4)
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