IMMUNIZATION DOCUMENTATION

In accordance with North Dakota State College of Science policy, the following immunization documentation is required. For more information on immunizations, visit NDSCS.edu/HealthServices or call 701-671-2286.

Possible resources for students to locate copies of immunization documentation include:
- State immunization registry
- Primary care providers
- High school transcripts
- Military records

REQUIRED INFORMATION

Name

_______________________________________________________________________________________________

Last First Middle Initial Former

Birthdate __________________________ NDSCS ID # __________________________ Phone __________________________

Month/Day/Year

SUBMIT YOUR DOCUMENTATION

MAIL
NDSCS Student Health Services
800 6th Street North
Wahpeton, ND 58076

EMAIL
NDSCS.StudentHealth@ndscs.edu

FAX
701-671-2356

MEASLES, MUMPS, RUBELLA (MMR) Two doses OR proof of TITER

MMR #1 (Must be given on or after first birthday)
Month ____________  Day ________  Year ________

MMR #2 (Must be at least 28 days after first MMR)
Month ____________  Day ________  Year ________

TITER Results
Laboratory blood test results showing immunity to measles, mumps and rubella is acceptable. You must attach each lab (titer) result which needs to include the date and value.

MENINGOCOCCAL VACCINATION (Please note Meningitis-B does not meet this requirement)

All students ages 21 and under must provide documentation of immunity against meningococcal disease. Vaccination must be AFTER 16th birthday.

Last Meningitis Vaccination Date  Month ____________  Day ________  Year ________

TUBERCULOSIS (TB)
Have you traveled or lived in a country outside the United states for more than 30 days?  □ Yes  □ No

Countries __________________________________________  Date of Return to U.S. __________________________

If travel was to a country classified by U.S. Health Officials as high risk for TB, attach two step mantoux testing or a chest X-ray indicating no active disease.

HEALTH CARE INFORMATION (This section must be completed or the form will NOT be accepted)

Health Care Provider’s Printed Name ________________________________________________

Health Care Provider’s Signature ___________________________________________________

Date __________________________  Facility Name/Location ________________________________________