NDSU STUDENT HEALTH SERVICE

DIVISION OF STUDENT AFFAIRS
NORTH DAKOTA STATE UNIVERSITY

Immunization Documentation

In accordance with North Dakota State University policy, the following immunization documentation is required. For more information on immunizations, visit www.ndsu.edu/studenthealthservice or call 701-231-7331.

DEADLINES: This documentation must be submitted by Aug. 1 for the fall semester, by Jan. 1 for the spring semester and May 1 for summer session.

- **DOCUMENTATION MUST BE SUBMITTED IN ENGLISH**
- **MUST LIST DATE OF EACH IMMUNIZATION**

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 _____ NDSU ID# _____ Phone# _____
Month/Day/Year

SUBMIT YOUR DOCUMENTATION

Online Student Health Portal:
www.ndsu.edu/studenthealthservice
Student Health Portal

Email:
ndsu.immunizations@ndsu.edu

Fax:
701-231-6132

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)

Are you 21 years of age or younger?

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

Meningitis Vaccination Date: Month: _____ Day: _____ Year: _____

❑ No This requirement does not apply to students 22 years of age and older.

TUBERCULOSIS (TB)

Have you traveled or lived in a country outside of the United States for more than 30 days? Yes ❑ No ❑

Countries_____

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

Health Care Professional's printed name: _____

Health Care Professional's signature: _____

Date: _____ Facility name/location: _____