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**

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<th>Name</th>
<th>Last</th>
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<th>Middle initial</th>
<th>Former</th>
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<tr>
<th>Birthdate</th>
<th>NDSU ID #</th>
<th>Phone #</th>
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<td>Month/Day/Year</td>
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**SUBMIT YOUR DOCUMENTATION**

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

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 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**

I am 21 years of age or younger  Yes ❑  No ❑

If yes, all students ages 21 and under must provide documentation of immunity against meningococcal disease. Vaccination must be AFTER 16th birthday. If no, students 22 and older do not have to complete this section.

**Meningitis Vaccination Date:**  Month: _______ Day: _______ Year: _______

**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 form will NOT be accepted if this section is not completed.)

Health Care Professional’s signature: ____________________________

Date: ___________  Facility name/location: ____________________________