SOUTHEAST Technical College

MEASLES, MUMPS & RUBELLA (MMR)
IMMUNIZATION REQUIREMENT
to Enroll at Southeast Tech

Due to regulations mandated by the State of South Dakota, ALL students entering a post-secondary institution for the first time after July 1, 2008, must document their immune status for measles, mumps and rubella (MMR). Proof of two doses of the MMR vaccine; OR two doses of measles, mumps and rubella vaccine; OR the presence of immune antibody titers for measles, mumps and rubella shall be required. **Students who fail to provide the required, signed proof of immunization, or file an exemption for religious or medical reasons, within 45 days from the beginning of the semester shall not be permitted to continue to attend classes until in compliance.** Students born before January 1, 1957 are exempt from providing immunization documentation.

Email this form or a record generated by your physician or clinic (i.e., Sanford MyChart or Avera Chart) to the Admissions Office at Admissions@southeasttech.edu.

IMMUNIZATION RECORD

Name _____ Birthdate _____/_____/_____
Last First Middle

Address _____

FIRST IMMUNIZATION
Administered on 1st birthday or later.
(Immunization prior to 1st birthday is not acceptable)

MMR (MR) _____/_____/_____ (month day year)

SECOND IMMUNIZATION
Administered 30 days or more after the first immunization.

MMR (MR2) _____/_____/_____ (month day year)

OR

Measles (Rubeloa) (RO) (Red Measles) _____/_____/_____ (month day year)

Measles (Rubeola) (RO2) _____/_____/_____ (month day year)

Rubella (RU) (German measles) _____/_____/_____ (month day year)

Rubella (RU2) _____/_____/_____ (month day year)

Mumps (MU) _____/_____/_____ (month day year)

Mumps (MU2) _____/_____/_____ (month day year)

OR

Rubeloa Titer (ROT); Positive Results Date _____/_____/_____ (Please attach lab results)
OR _____ Had disease, confirmed by office record; Date _____/_____/_____
Rubella Titer (RUT); Positive Results Date _____/_____/_____ (Please attach lab results)
OR _____ Had disease, confirmed by office record; Date _____/_____/_____
Mumps Titer (MUT); Positive Results Date _____/_____/_____ (Please attach lab results)
OR _____ Had disease, confirmed by office record; Date _____/_____/_____

Signature _____ Date _____/_____/_____

(Must be signed by a Primary Care Provider or Nurse)

Updated: April 5, 2024