Georgia State University

Required Certificate of Immunization

(Return this to the institution)

Retain a copy of the completed form for your records.

STUDENT INFORMATION

Student ID ----------

Name: (Last)_____(First)_____(Middle)_____

Address: _____

City:_____State:_____Country:_____Zip Code: _____

Term/Year of Application:_____Age at time of application:_____Date of Birth:_____/_____/_____

REQUIRED IMMUNIZATION INFORMATION

VACCINE	DATE MM/DD/YYYY	DATE MM/DD/YYYY	DATE MM/DD/YYYY	HISTORY	DATE OF POSITIVE LAB/SEROLOGIC EVIDENCE
MMR[1]	/ /	/ /			
Measles[1]	/ /	/ /			/ /
Mumps[1]	/ /	/ /			/ /
Rubella[1]	/ /	/ /			/ /
Varicella[3]	/ /	/ /		(or history of Varicella) / /	
Tetanus-Diphtheria Pertussis (Whooping Cough)[4]	/ / Tdap	/ / Td Boost[4] er			
Hepatitis B[2]	/ /	/ /	/ /	Type Series: ☐ 2 Dose Series ☐ 3 Dose Series	/ /

1—Not required if born before 1957 2—Only required of students who are 18 years of age or younger at time of expected matriculation.

3—Required for all US born students born in 1980 or later; all foreign born students regardless of year born. 4 – Td booster only necessary if >_10 years since Tdap dose.

PERMANENT OR TEMPORARY IMMUNIZATION EXEMPTION

☐ This student is exempt from the above immunizations on the ground of permanent medical contraindication.

☐ This student is temporarily exempt from the above immunization until_____/_____/_____.

CERTIFICATION OF HEALTH CARE PROVIDER *(This information is required)*

Name:_____Signature:_____

Address:_____

Date of Issue:_____/_____/_____Telephone: _____

EXEMPTIONS

Check the appropriate box, sign, and date if you are claiming exemption of the immunization requirement for one of the following reasons:

☐ I affirm that Immunization as required by the University System of Georgia is in conflict with my religious beliefs. I understand that I am subject to exclusion in the event of an outbreak of a disease for which immunization is required.

Student Signature:_____Date:_____/_____/_____

☐ I declare that I will be enrolling in ONLY courses offered by distance learning. I understand that if I register for a course that is offered on-campus or at a campus-managed facility this exemption becomes void and I will be excluded from class until I provide proof of immunization.

Student Signature:_____Date:_____/_____/_____

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Term/Year of Application: _____ Age at time of application: _____ Date of Birth:_____/_____/_____

RECOMMENDED IMMUNIZATION INFORMATION

VACCINE	DATE MM/DD/YYYY	DATE MM/DD/YYYY	DATE MM/DD/YYYY	HISTORY	DATE OF POSITIVE LAB/SEROLOGIC EVIDENCE
Human Papillomavirus[5]	/ /	/ /	/ /		
Hepatitis A[6]	/ /	/ /	/ /	Type Series: ☐ 2 Dose Series ☐ 3 Dose Series	/ /
Meningococcal ACWY [7, 8] (MCV4)	/ /	/ / MCV4 Booster[8]			
Meningococcal B[9]	/ /	/ /	/ /	Type Series: ☐ 2 Dose Series ☐ 3 Dose Series	
Annual Influenza[6]	/ /	/ /			

5 – Strongly recommended for all unvaccinated males and females through age 26 years.
6 - Strongly recommended but not required.
7 – Strongly recommended if residing in campus housing, sorority housing, or fraternity housing.
8 – MCV4 Booster necessary if initial MCV4 dose was received more than 5 years prior to admittance.
9 - Consider if younger than 23 yrs of age.

CERTIFICATION OF HEALTH CARE PROVIDER (This information is required)

Name:_____Signature:_____

Address:_____

Date of Issue:_____/_____/_____Telephone: _____

Student Signature:_____Date:_____/_____/_____