



CERTIFICATE OF IMMUNIZATION

Return form to: Student Health Services 504 College Drive Albany, Georgia 31705 or Fax to 229- 500-3544 Office 229-500-4918

As required under University System Policy, this form must be completed and returned to Student Health Services before the student will be eligible for enrollment. Retain a copy for your records.

STUDENT INFORMATION

Student ID: _____ - _____ - _____ Date of Birth: ____/____/____ Male____Female____

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

Address: _____

City: _____ State: _____ Zip Code: _____

REQUIRED IMMUNIZATION INFORMATION

Table with 6 columns: VACCINE, DATE MM/DD/YYYY, DATE MM/DD/YYYY, DATE MM/DD/YYYY, HISTORY, DATE OF POSITIVE LAB/SEROLOGIC EVIDENCE. Rows include MMR1, Measles1, Mumps1, Rubella1, Varicella2, Tetanus (Tdap or TD with 10 Years), Meningococcal3, Hepatitis B4, PPD 5/, and Chest X-Ray.

1-Not required if born before 1957 2-Required for all students born in 1966 or later; or date of Chicken Pox disease. 3-Required of newly admitted freshmen and students planning to live in campus housing. 4-Required based on major. Strongly recommended for all students. 5-Required of all students; must have been done no more than 3 months prior to start of class. . Chest X-ray required if history of positive PPD. 6-Immunizations are not required, but strongly encouraged, if enrolled in a 100% online program.

PERMANENT OR TEMPORARY IMMUNIZATION EXEMPTION

- This student is exempt from the above immunizations on the ground of permanent medical contraindication. (Letter must be attached)
□ This student is temporarily exempt from the above immunization until ____/____/____.

CERTIFICATION OF HEALTH CARE PROVIDER (This information is required)

Name _____ Signature: _____

Address _____ City _____ State _____ Zip Code _____

Date of Issue ____/____/____ Telephone: _____