

CERTIFICATE OF IMMUNIZATION

University System of Georgia

PART A - To be completed by student

Name _____
LAST FIRST MIDDLE INITIAL

Date of Birth _____ Social Security # _____

Address _____
STREET CITY STATE ZIP

Expected Semester and year of Enrollment _____
Semester Year

PART B - To be completed and signed by a health care provider. Dates must include month and year.

Required Immunizations:

- For students born in or before 1957, Rubella immunity, as in IV.
- For all other students, either MMR immunity, as in I or measles, mumps and rubella immunity, as in II, III and IV.

I. MMR (Measles, Mumps, Rubella) *Note: Date must be after 1970*

- Dose 1 - immunized at 12 months of age or later, **and** (MO/DAY/YR) ___/___/___
- Dose 2 - immunized at least 30 days after Dose 1. (MO/DAY/YR) ___/___/___

II. MEASLES *Note: Date must be after March 4, 1963*

- Had disease, confirmed by physician diagnosis in office record, **OR** (MO/DAY/YR) ___/___/___
- Born in or before 1957 and therefore considered immune, **OR** (MO/DAY/YR) ___/___/___
- Has laboratory evidence of immune titer (specify date of titer), **OR** (MO/DAY/YR) ___/___/___
- Immunized with live measles vaccine at 12 mos. of age or later, **AND** (MO/DAY/YR) ___/___/___
- Immunized with second dose of live measles vaccine at least 30 days after first dose (MO/DAY/YR) ___/___/___

III. MUMPS *Note: Date must be after April 22, 1971*

- Had disease, confirmed by physician diagnosis in office record, **OR** (MO/DAY/YR) ___/___/___
- Born in or before 1957 and therefore considered immune, **OR** (MO/DAY/YR) ___/___/___
- Has laboratory evidence of immune titer (specify date of titer), **OR** (MO/DAY/YR) ___/___/___
- Immunized with vaccine at 12 mos. of age or later (MO/DAY/YR) ___/___/___

IV. RUBELLA *Note: Date must be after June 9, 1969*

- Has laboratory evidence of immune titer (specify date of titer), **OR** (MO/DAY/YR) ___/___/___
- Immunized with vaccine at 12 mos. of age or later (MO/DAY/YR) ___/___/___

- Exemption on grounds of permanent medical contraindication
 Exemption on grounds of temporary medical contraindication
a) pregnancy - expected date of confinement
b) other - anticipated date of end of contraindication

(MO/DAY/YR) ___/___/___
(MO/DAY/YR) ___/___/___

Immunization status indicated above is certified by:

Signature of physician or health facility official Date

Name and address of physician or public health facility

RELIGIOUS EXEMPTION

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 from campus in the event of an outbreak of a disease for which immunization is required.

Signature of Student (*Student signature required only for religious exemption*) Date