Certificate of Immunization - University System of Georgia

All new students must submit a completed University System of Georgia Certificate of Immunization as a condition of admission. This certificate must be on file before the student can enroll in classes.

Part A - To be completed by student

Name: ____ Date of Enrollment____________
Last First Middle/Maiden

Date of Birth ______________________ SSN__________________________
Address ____
Street City State Zip

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

Required Immunization
For students born before 1957: Rubella immunity, as in IV.
For students born in or after 1957: either (a) MMR immunity, as in I or (b) measles, mumps, and rubella immunity, as in II, III, and IV.

		Month / Day / Year
I.	**MMR (Measles, Mumps, Rubella)** *Note: Date must be after 1970*	
	1. ___ Dose 1 - immunized at 12 months of age or later	_____ / ___ / ____
	2. ___ Dose 2 - immunized at least 30 days after Dose 1	_____ / ___ / ____
II.	**Measles** *Note: Date must be after March 4, 19963*	
	1. ___ Had disease, confirmed by physician diagnosis in office record, OR	_____ / ___ / ____
	2. ___ Born before 1957 and therefore considered immune, OR	_____ / ___ / ____
	3. ___ Has laboratory evidence of immune titer (specify date of titer), OR	_____ / ___ / ____
	4. ___ Immunized with live measles vaccine at 12 months of age or later, AND	_____ / ___ / ____
	5. ___ Immunized with second dose of live measles vaccine at least 30 days after first dose	_____ / ___ / ____
III.	**Mumps** *Note: Date must be after June 9, 1969*	
	1. ___ Had disease, confirmed by physician diagnosis in office record, OR	_____ / ___ / ____
	2. ___ Born before 1957 and therefore considered immune, OR	_____ / ___ / ____
	3. ___ Has laboratory evidence of immune titer (specify date of titer), OR	_____ / ___ / ____
IV.	**Rubella** *Note: Date must be after June 9, 1969*	
	1. ___ Had disease, confirmed by physician diagnosis in office record, OR	_____ / ___ / ____
	2. ___ Immunized with live measles vaccine at 12 months of age or later	_____ / ___ / ____
	___ 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	_____ / ___ / ____

____ ____________________
Signature of Physician or Health Care Official Date

Name of Physician or Public Health Facility______________________________________
Physician / Facility Address ____

Religious Exemption - *I affirm that immunizations required by the University System of Georgia are 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.*

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

Return to: Savannah State University, P.O. Box 20209, Savannah, GA 31404. Note: Students are recommended to keep a photocopy of this form.