UNIVERSITY SYSTEM OF GEORGIA
REQUIRED
CERTIFICATE OF IMMUNIZATION

(Return this to the institution)

Return documentation to the college or university that you are applying to. Retain a copy of the completed form for your records.

STUDENT INFORMATION

Social Security Number/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(See the Immunization Requirements & Recommendations for USG Students documentation)

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	/ /	/ /		(History of Varicella) / /	/ /
Tetanus-Diphtheria (DTP, DTaP, Tdap, or Td within 10 years)	(Most recent date) / /				
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.

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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RECOMMENDED IMMUNIZATION INFORMATION (See the Immunization Requirements & Recommendations for USG Students documentation)

VACCINE	DATE MM/DD/YYYY	DATE MM/DD/YYYY	DATE MM/DD/YYYY	HISTORY	DATE OF POSITIVE LAB/SEROLOGIC EVIDENCE
Human Papillomavirus 4	/ /	/ /	/ /		
Hepatitis A 5	/ /	/ /	/ /	Type Series: ☐ 2 Dose Series ☐ 3 Dose Series	/ /
Meningococcal 5	/ /	/ /			
Influenza 5	/ /	/ /	/ /		

4 – Strongly recommended for all unvaccinated women through age 26 years. 5 - Strongly recommended but not required.

CERTIFICATION OF HEALTH CARE PROVIDER (This information is required)

Name: _____ Signature: _____

Address: _____

Date of Issue: _____/_____/_____ Telephone: _____

Student Signature: _____ Date: _____/_____/_____