FORT VALLEY STATE UNIVERSITY
University System of Georgia
CERTIFICATE OF IMMUNIZATION
(Return this form to the Institution)

Part I – To be completed by the Student

Student ID: ______________________________ Social Security Number _______ - _____ - _____

Name ___________________________________ ___________________________________
Last Name First Name

Address ____
Street City State Zip

Age __________ at time you enter college Date of Birth _______/ ______/ ______
MM DD YR

Signature ____

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Part II – To Be Completed and Signed By Your Health Care Provider

Required Immunizations

A. Measles, Mumps Rubella. Required for students born in 1957 or later

(Mo/Day/Yr) ____/ ____/ ____
(Mo/Day/Yr) ____/ ____/ ____

1. M.M.R. (Measles, Mumps, Rubella)
___ 2 Doses with the first dose at 12 months or later and the second at least 28 days after the first dose, **OR**
___ Laboratory/serologic evidence of immunity

OR

2. Measles

(Mo/Day/Yr) ____/ ____/ ____
(Mo/Day/Yr) ____/ ____/ ____

___ 2 Doses with the first dose at 12 months or later and the second at least 28 days after the first dose, **OR**
___ Laboratory/serologic evidence of immunity

Mumps

(Mo/Day/Yr) ____/ ____/ ____
(Mo/Day/Yr) ____/ ____/ ____

___ 1 Dose at 12 months or later, **OR**
___ Laboratory/serologic evidence of immunity

Rubella

(Mo/Day/Yr) ____/ ____/ ____
(Mo/Day/Yr) ____/ ____/ ____

___ 1 Dose with the first dose at 12 months or later, **OR**
___ Laboratory/serologic evidence of immunity

OR

3. Exemption

(Mo/Day/Yr) ____/ ____/ ____
(Mo/Day/Yr) ____/ ____/ ____

___ I was born between 1957, and therefore am exempt from this requirement

B. Tetanus-Diphtheria (Td booster dose in the last ten years or Primary Series with DTaP, DTP or Td)

(Mo/Day/Yr) ____/ ____/ ____
(Mo/Day/Yr) ____/ ____/ ____

___ One Td booster dose within the last ten years prior to matriculation, **OR**
___ Completion of primary series (DTaP, DTP or TD) within the last ten years prior to matriculation

C. Varicella (Either a history of chicken pox, a positive Varicella antibody, or two doses of vaccine given at Lease one month apart if immunized after age 13 years.)

___ History of Disease Yes _____ No _____, **OR**
(Mo/Day/Yr) ____/ ____/ ____ ___ Laboratory/serologic evidence of immunity, **OR**
(Mo/Day/Yr) ____/ ____/ ____ ___ 1 Dose given at 12 months of age or later but before the student's 13th birthday, **OR**
___ 2 Doses, Dose 1 given after the student's 13th birthday. 2nd dose at one month after first dose.

D. Hepatitis B – Required of all students who are 18 years of age or younger. (Three doses of vaccine or a positive Hepatitis surface antibody)

___ 3 dose hepatitis B series, **OR**
Dose 1 ____/ ____/ ____ ___ 3 dose combined hepatitis A and hepatitis B series, **OR**
Dost 2 ____/ ____/ ____ ___ 2 doses hepatitis B series of Recombivax, **OR**
Dose 3 ____/ ____/ ____ ___ Laboratory/serologic evidence of immunity or prior infection

E. Exemption

____ This student is exempt from the above immunization on grounds of permanent medical contraindication.

____ This student is temporarily exempt from the above immunizations until _____/ _____/ _____

Health Care Provider

Name ____________________________________ Address ____________________________________

Signature ________________________________ Phone (______) ______________________________

Date ________________________________

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Part III – Exemptions

___ 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.

OR

___ 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 immunizations.

F. TUBERCULOSIS SCREENING (PPD required regardless of prior BCG inoculation.) This section to be updated in early 2000 when new CDC guidelines are published.

1. PPD (Mantoux) within the past 12 months (tine or monovac not acceptable)
(Mo/Day/Yr) ____/ ____/ ____