San Francisco State University - IMMUNIZATION REQUIREMENTS

All students must provide proof of immunization before they may register for classes. The SHS recommends that students are up to date with all vaccinations

http://www.cdc.gov/vaccines/spec-grps/college.htm

Note: Students who were enrolled in a California public school for the seventh grade or higher on or after July 1, 1999 ARE NOT currently required to complete and submit this form to provide proof of immunization against Measles, Rubella and Hepatitis B, HOWEVER, students are advised to do so as the requirements will change in the very near future.

LAST NAME _____ FIRST NAME _____

ADDRESS _____

PHONE NUMBER _____ DATE OF BIRTH _____

STUDENT ID _____ EMAIL _____ MAJOR _____

Please complete the rest of this form OR Attach copies of your immunization records

Mail or Bring this form in person to:	**Questions?**
Registrar's Office, SSB 101 **San Francisco State University** **1600 Holloway Avenue** **San Francisco, CA 94132**	**Registrar, One Stop** **Student Service Center, SSB 101** **Phone: (415) 338-2350** **Fax: (415) 338-0588** **http://health.sfsu.edu/required.html**
ALL STUDENTS* BORN AFTER 1957	STUDENTS 18 YEARS OR YOUNGER
Measles, Mumps, Rubella (MMR) Vaccine Date of immunization #1 _____ Date of immunization #2 _____ OR Results of a blood test indicating immunity Date of blood test _____ Results _____ If you were born before 1957, check with your academic department to see if immunizations are needed for curriculum requirements e.g. Enrolled in Dietetics, Medical Technology, Nursing, Physical Therapy or any Practicum, Student Teaching or Field Work involving Pre-school Children or taking place in a Hospital or Health Care Setting.	Hepatitis B Vaccine Date of dose #1 _____ Date of dose #2 _____ Date of dose #3 _____ OR Results of a blood test indicating immunity Date of blood test _____ Test performed _____ Results _____ **Also NEED Proof of MMR Vaccination - See Previous Column**
CERTIFICATION BY MD/RN Name _____ Address _____ Date _____	CERTIFICATION BY MD/NP/PA/RN Name _____ Address _____ Date _____
Office Stamp	Office Stamp

WAIVERS/EXEMPTIONS MMR/HEP B - CONTACT THE REGISTRAR'S OFFICE (SEE ABOVE) - WE ACCEPT COPIES - DO NOT SUBMIT ORIGINALS