

CERTIFICATE OF IMMUNIZATION

All fields must be completed

Mail completed form to:
Office of Student Health Services
University of West Georgia
Carrollton, Ga. 30118-4700
678-839-6452
www.westga.edu/~health

Name _____ Social Security Number _____
Last First Middle Student ID Number (required) _____

Date of Birth _____ Semester and Year Entering West Georgia _____

Required Immunizations—These immunizations are required by the Board of Regents of the University System of Georgia. Student cannot register for classes without this evidence of immunization. This certificate must be completed and signed by a health care provider. Dates must include month and year, or month, day and year where indicated.

IMMUNIZATION INFORMATION

VACCINE	DATE MM/DD/YYYY	DATE MM/DD/YYYY	DATE MM/DD/YYYY	SERIES	DATE OF POSITIVE LAB/ SEROLOGICAL EVIDENCE
MMR	/ /	/ /			
Measles	/ /	/ /			/ /
Mumps	/ /	/ /			/ /
Rubella* (Before Age 13)	/ /	/ /			/ /
Varicella (Before Age 13)	/ /	/ /			(or history of varicella) / /
Tetanus-Diphtheria (DPT, DtaP, Tdap, or TD within 10 years)	(Most recent date) / /				
Hepatitis B*	/ /	/ /	/ /	Type Series: <input type="checkbox"/> 2 Dose Series <input type="checkbox"/> 3 Dose Series	/ /

Recommended Immunizations

Meningococcal	/ /	/ /			/ /
Hepatitis A	/ /	/ /			/ /

•For students born before 1957, provide evidence of Rubella immunity.

*For students born after January 1, 1987

Immunization status indicated above is certified by:

_____/_____/_____
Signature of physician or health facility official Date Name and address of Healthcare provider

- VIII. ☐ Temporary medical exemption until ____/____/____ or
☐ Permanent medical exemption
 Medical reason for request _____
 (Must be verified by a doctor)
- ☐ Religious exemption: I affirm that immunization as required by the University System of Georgia is in conflict with my religious beliefs.
 I understand that exemption for any of the reasons listed above subjects me to exclusion from campus in the event of an outbreak of a disease for which immunization is required.
- Student Signature _____

The information on this form is confidential and will be used only in matters concerning your health..

NOTE: It is recommended that the student keep a photocopy for future use.