MANDATORY
CERTIFICATE OF IMMUNIZATION

University Health Center
The University of Georgia
Athens, GA 30602-1755
706-542-8617 Health Information
706-542-4959 Fax

Name ____________________________ **Date of Birth** _____________ **SSN** ____________________

VACCINE	REQUIREMENT	REQUIRED FOR:
MMR (Measles, Mumps, Rubella) combined shot	•**2 Doses** #1 ____/____/____ #2 ____/____/____	• Students born in 1957 or later
Measles (Rubeola)	• **2 Doses** #1 ____/____/____ #2 ____/____/____ • **or Titer** ____/____/____	• Students born in 1957 or later • If titer done, attach results.
Mumps	• **2 Doses** #1 ____/____/____ #2 ____/____/____ • **or Titer** ____/____/____	• Students born in 1957 or later • If titer done, attach results
Rubella (German Measles)	•**1 Dose** #1 ____/____/____ • **or Titer** ____/____/____	• All students • If titer done, attach results
Varicella (Chicken Pox)	• **2 Doses** #1 ____/____/____ #2 ____/____/____ • **or History** of chicken pox or shingles ____/____/____ • **or Titer** ____/____/____	• All U.S. born students born in 1980 or later • All foreign born students regardless of year born • If titer done, attach results
Tetanus and Diphtheria (Td or Tdap)	• **Td** ____/____/____ • **or Tdap** ____/____/____	• All students must have one dose within 10 years
Hepatitis B	• **3 Dose series** #1 ____/____/____ #2 ____/____/____ #3 ____/____/____	• All students 18 years of age or less at matriculation

RECOMMENDED IMMUNIZATIONS

Hepatitis A #1 ____/____/____
#2 ____/____/____

HPV #1 ____/____/____
#2 ____/____/____
#3 ____/____/____

Meningitis ____/____/____

Tuberculosis screening skin test ____/____/____
Results: ☐ negative ☐ positive
If positive, attach chest x-ray report from US healthcare facility
X-ray result: Date ____/____/____
☐ negative ☐ abnormal

REQUEST FOR EXEMPTION

☐ Temporary medical exemption until ____/____/____
(attach verification by a doctor)

or

☐ Permanent medical exemption
(attach verification by a doctor)
Medical reason:
____
____

☐ Religious exemption
(attach verification by religious leader)
Religious reason:
____
____

REQUIRED SIGNATURE OF PHYSICIAN OR HEALTH FACILITY

Name ______________________________ Address ______________________________

Signature ______________________________ ______________________________

Date ______________________________ Phone ______________________________ 1/08