Georgia College & State University
Certificate of Immunization

STUDENT INFORMATION
GCID _______________-__________-__________________

Name___________________________________________________________________________________________________________________

Last                                                                                                 First                                                                    Middle
Address _________________________________________________________________________________________________________________

City______________________________________________________________________________ State_________________Zip ______________

Term/Year of application ________________________   Age at time of enrollment__________________   Date of Birth________/ ________/ _______

IMMUNIZATION INFORMATION  (See the reverse of this form for specific immunization requirements.)

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>DATE MM/DD/YY</th>
<th>DATE MM/DD/YY</th>
<th>DATE MM/DD/YY</th>
<th>DATE MM/DD/YY</th>
<th>DATE OF POSITIVE LAB/SERLOGIC EVIDENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMR</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
<td></td>
</tr>
<tr>
<td>Measles</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
<td></td>
</tr>
<tr>
<td>Rubella</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
<td></td>
</tr>
<tr>
<td>Varicella (Chicken Pox)</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
<td>/ /</td>
<td>(or history of varicella)</td>
</tr>
<tr>
<td>Tetanus-Diphtheria</td>
<td>/ /</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Hepatitis B*             | / /           | / /           | / /           | / /           | Type Series

*Only required of students who are 18 years of age or younger at time of expected enrollment.

For students born before 1957, the following immunizations are required: Varicella, and Tetanus.

EXEMPTIONS
☐ This student is exempt from the above immunizations on the grounds of medical contraindication.

☐ This student is temporarily exempt from the above immunization until _____/_____/_____

   A. ☐ Distance Learning/Study Abroad  I declare that I will be enrolling in ONLY courses offered by distance learning or never to attend a course offered on campus or a campus managed facility. 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.

   B. ☐ Pregnancy-expected date of confinement_____/_____/_____.

CERTIFICATION OF HEALTH CARE PROVIDER (This information is required.)

Name___________________________________________________Signature ________________________________________________________

Address _________________________________________________________________________________________________________________

Date of Issue__________________________

☐ 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___________________________

PLEASE RETURN THIS FORM TO:
Georgia College & State University
Office of the Registrar
Campus Box 69
Milledgeville, GA 31061
or fax to (478) 445-1914
# Immunization Requirements

(Effective Fall Semester 2005)

According to the policies of the Board of Regents of the University System of Georgia, applicants who have not previously attended Georgia College & State University must submit proof of all required immunizations certified by a health official. Applicants may obtain vaccinations by visiting their family physician or local health department.

## PROOF OF IMMUNIZATION OR NATURALLY-ACQUIRED IMMUNITY – REQUIRED

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>REQUIREMENT</th>
<th>REQUIRED FOR:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles (Rubeola)</td>
<td>Two (2) doses of live measles vaccine (combined measles-mumps-rubella or “MMR” meets this requirement), with first dose at 12 months of age or later and second dose at least 28 days after the first dose OR Laboratory/serologic evidence of immunity</td>
<td>Students born in 1957 or later</td>
</tr>
<tr>
<td>Mumps</td>
<td>One (1) dose at 12 months of age or later (MMR meets this requirement) OR Laboratory/serologic evidence of immunity</td>
<td>Students born in 1957 or later</td>
</tr>
<tr>
<td>Rubella (German Measles)</td>
<td>One (1) dose at 12 months of age or later (MMR meets this requirement) OR Laboratory/serologic evidence of immunity</td>
<td>Students born in 1957 or later</td>
</tr>
<tr>
<td>Varicella (Chicken Pox)</td>
<td>One (1) dose at 12 months of age or later but before the student’s 13th birthday OR If first dose given after the student’s 13th birthday: Two (2) doses at least 4 weeks apart OR Medical history of varicella disease OR Laboratory/serologic evidence (blood test) of immunity</td>
<td>All Students</td>
</tr>
<tr>
<td>Tetanus, Diphtheria</td>
<td>One Td booster dose within 10 years prior to matriculation. Recommendation: Students who are unable to document a primary series of three (3) doses of tetanus containing vaccine (DtaP, DTP, or Td) are strongly advised to complete a three (3) dose primary series with Td.</td>
<td>All Students</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Three (3) dose hepatitis B series (0, 1-2, and 4-6 months) OR Three (3) dose combined hepatitis A and hepatitis B series (0, 1-2, and 6-12 months) OR Two (2) dose hepatitis B series of Recombivax (0 and 4-6 months, given at 11-15 years of age) OR Laboratory/serologic evidence of immunity or prior infection</td>
<td>Required for all students who will be 18 years of age or younger at time of expected matriculation. Recommendation: It is strongly recommended that all students, regardless of their age at matriculation, discuss hepatitis B immunization with their health care provider. Entire series must be taken in increments as directed by their physician or Health Department.</td>
</tr>
</tbody>
</table>