



CERTIFICATE OF IMMUNIZATION
2007-2008

Part I - To be completed by the Student

RAM ID # ___-___-___

Name Last Name First Name

Address Street City State Zip

Date of Birth / / M F Signature: _____

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.

1. M.M.R. (Measles, Mumps, Rubella)

- a. Dose 1 / /
b. Dose 2 / /
c. Laboratory/serologic evidence of immunity / /

OR

2. Measles

- a. Dose 1 / /
b. Dose 2 / /
c. Laboratory/serologic evidence of immunity / /

3. Mumps

- a. Dose 1 / /
b. Laboratory/serologic evidence of immunity / /

4. Rubella

- a. Dose 1 / /
b. Laboratory/serologic evidence of immunity / /

5. Exemption

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

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

- a. One Td booster dose within the last ten years prior to matriculation / /

OR

- b. 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 least one month apart if immunized after age 13 years.

- a. History of disease Yes What Year? No

OR

- b. Laboratory/serologic evidence of immunity / /

OR

- c. 1 dose given at 12 months of age or later but before the student's 13th birthday / /

- d. 2 doses. Dose 1 give after the 13th birthday. 2nd dose at one moth after first dose.

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University System of Georgia

Albany State University

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**C. Hepatitis B-18 years and/or younger
Three doses of vaccine or a positive Hepatitis surface antibody.**

- 1. Hepatitis B series
 - a. Dose 1 ___/___/___
 - b. Dose 2 ___/___/___
 - c. Dose 3 ___/___/___

OR

- 2. Laboratory /serologic evidence of immunity or prior infection ___/___/___

D. TB Test and/or Chest X-Ray—Required of all students

- A. TB Test Given _____ Date _____ Results _____
- B. Chest X-Ray _____ Date _____ Results _____

E. Meningococcal Polysaccharide Vaccine—Required of all students living on campus

Meningococcal Vaccine ___/___/___

F. Exemption

___ This student is exempt from all 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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