University System of Georgia

REQUIRED

CERTIFICATE OF IMMUNIZATION

This form must be completed by all new students. The information herein is confidential and will be released only upon your written request. The form must be signed, dated, and addressed by a medical care provider. East Georgia State College retains the right to deny any immunization record deemed questionable and may request further medical documentation. Failure to complete this form may prevent you from enrolling at East Georgia State College. A suggested deadline to submit this form is at least 2 weeks prior to the first day of class. **Please mail this completed form to: Admissions, East Georgia State College, 131 College Circle, Swainsboro, GA 30401-8043**.

To be completed by student. Retain a copy of the completed form for your records.

Social Security Number OR Student ID: _____ Today's Date: _____

Name: _____
Last Name First Name Middle Name

Address: _____

City: _____ State: _____ Zip: _____

Term/Year of Application: _____ Age: _____ at time you will enter college Date of Birth: _____

Student's Signature: _____ Phone Number: (_____)_____

REQUIRED IMMUNIZATION INFORMATION (See the Immunization Requirements & Recommendations for USG Students documentation)

VACCINE	DATE MM/DD/YYYY	DATE MM/DD/YYYY	DATE MM/DD/YYYY	HISTORY	DATE OF POSITIVE LAB/SEROLOGIC EVIDENCE
MMR 1	/ /	/ /			
Measles 1	/ /	/ /			/ /
Mumps 1	/ /	/ /			/ /
Rubella 1	/ /	/ /			/ /
Varicella 3	/ /	/ /		(History of Varicella) / /	/ /
Tetanus-Diphtheria (DTP, DTaP, Tdap, or Td within 10 years)	(Most recent date) / /				
Hepatitis B 2	/ /	/ /	/ /	Type Series: ☐ 2 Dose Series ☐ 3 Dose Series	/ /

1—Not required if born before 1957. 2—Only required of students who are 18 years of age or younger at time of expected matriculation.
3—Required for all US born students born in 1980 or later; all foreign born students regardless of year born.

PERMANENT OR TEMPORARY IMMUNIZATION EXEMPTION

☐ This student is exempt from the above immunizations on the ground of permanent medical contraindication.

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

CERTIFICATION OF HEALTH CARE PROVIDER (This information is required)

Name: _____

Address _____

Telephone: _____

Date of Issue: _____ Signature: _____ **over →**