

Certificate of Immunization

University System of Georgia

NOTE: Students who have previously attended Armstrong State College / Armstrong Atlantic State University are not required to provide immunization records.

Part A – to be completed by student

Name _____
last first middle initial

Date of Birth _____ Social Security Number _____

Address _____
street city state zip

Expected term of enrollment _____

Part B – To be completed and signed by a health care provider. Dates must include month and year.

Required Immunizations:

1. For students born before 1957, rubella immunity, as in IV.
2. For all other student, either a) MMR immunity, as in I or b) measles, mumps and rubella immunity, as in II, III and IV.

I **MMR (Measles, Mumps, Rubella)** Note: date must be after 1970

1. Dose 1 – immunized at 12 months of age or later, and (mo/day/yr) ___/___/___
2. Dose 2 – immunized at least 30 days after Dose 1 (mo/day/yr) ___/___/___

II **Measles** Note: date must be after March 4, 1963

1. Had disease, confirmed by physician diagnosis in office record, or (mo/yr) ___/___
2. Born before 1957 and therefore considered immune, or (mo/yr) ___/___
3. Had laboratory evidence of immune titer (specify date of titer), or (mo/yr) ___/___
4. Immunized with live measles vaccine at 12 mos. Of age or later, and (mo/day/yr) ___/___/___
5. Immunized with second dose of live measles vaccine at least 30 days after first dose (mo/day/yr) ___/___/___

III **Mumps** Note: date must be after April 22, 1971

1. Had disease, confirmed by physician diagnosis in office record, or (mo/yr) ___/___
2. Born before 1957 and therefore considered immune, or (mo/yr) ___/___
3. Had laboratory evidence of immune titer (specify date of titer), or (mo/yr) ___/___
4. Immunized with vaccine at 12 mos. Of age or later (mo/day/yr) ___/___/___

IV **Rubella** Note: date must be after June 9, 1969

1. Had laboratory evidence of immune titer (specify date of titer), or (mo/yr) ___/___
2. Immunized with vaccine at 12 mos. Of age or later (mo/yr) ___/___

- Exemption on grounds of permanent medical contraindication
- Exemption on grounds of temporary medical contraindication
- a. Pregnancy – expected date of confinement (mo/yr) ___/___
 - b. Other – anticipated date of end of contraindication (mo/yr) ___/___

Immunization status indicated above is certified by:

Signature of physician or health facility official

Date

Name and address of physician or public health facility

Religious exemption

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 from campus in the event of an outbreak of a disease for which immunization is required.

Signature of student (required only for religious exemption)

Date