Fort Valley State University
A State and Land-Grant Institution • University System of Georgia

CERTIFICATE OF IMMUNIZATION
2008-2009

Part I- To be completed by the student

Name ______________________________________ ____
Last Name First Name

Address ____
Street City State Zip

Date of Birth _______/_________/______ ❑ M ❑ F SSN/Student ID# _______/_________/__________

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.

	Dose 1	Dose 2	Laboratory/serologic evidence of immunity
1. M.M.R. (Measles, Mumps, Rubella)	____/____/____	____/____/____	____/____/____
		or	
2. Measles	____/____/____	____/____/____	____/____/____
3. Mumps	____/____/____		____/____/____
4. Rubella	____/____/____	____/____/____	____/____/____

❑ **Exception**: I was born before 1957, and therefore I am exempt from this requirement

B. Meningococcal Polysaccharide Vaccine: Required of all students living on campus
Meningococcal Vaccine ____/____/____

C. Tetanus-Diphtheria (Td booster dose in the last ten years or Primary Series with DTap, DTP or TD)
1. One Td booster dose within the last ten years prior to matriculation ____/____/____
or
2. Completion of primary series (DTap, DTP or TD) within the last ten years prior to matriculation ____/____/____

D. 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. (Complete either 1, 2, or 3)

1. History of Disease ❑ Yes ❑ No If yes, what year: ____/____/____
2. Laboratory/serologic evidence of immunity ❑ N/A If applicable, list date: ____/____/____
3. First Dose - Given at 12 months of age or later but before student's 13th birthday ____/____/____
4. Second Dose – Given one month after first dose ____/____/____

E. Hepatitis B Series -18 years and/or younger. **Three dose** of vaccine or a positive surface antibody.
Dose 1: ___/_____/______ Dose 2: ___/_____/______ Dose 3: ___/_____/______
or
Laboratory/serologic evidence of immunity or prior infection ____/____/____

F. TB Test and/or Chest X-Ray: Required of all students
1. TB Test Given: ___/_____/______ Results: ______________________________mm
2. Chest X-Ray: ___/_____/_______ Results: ______________________________

G. Exemptions
❑ This student is exempt from all the above immunization on grounds of permanent medical contraindication.
❑ This student is temporarily exempt from the above immunization until ___/_____/______.

Health Care Provider

Name_________________________________ Signature________________________________ Date ___/_____/______

Address____ Phone (_____)____________________

Return to form to: Fort Valley State University • Health Services Center • 1005 State University Drive • Fort Valley, Georgia 31030
Please call (478) 825-6278 if you have any questions.