

I am a FULLY ONLINE Student _____

(Fully online=you will take all your classes online & never take any classes on campus.)



FVSU Student ID# _____

Male or Female (please circle)

Fully Online students:complete Part I ONLY.

CERTIFICATE OF IMMUNIZATION

Part I- To be completed by the student

Last Name _____ First Name _____ Date of Birth ____/____/____

Home Address _____
Street City State Zip

Cell Phone# _____ Home Phone# _____ Email _____

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. 1st dose must have been given after 1st birthday.

	Dose 1	Dose 2	Laboratory/serologic evidence of immunity
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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, two doses of vaccine given at least 28 days apart , or a positive Varicella antibody.)

- 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 (1st Dose has to have been given after 1995) ____/____/____
- 4. Second Dose – Given at least 28days after first dose ____/____/____

E. Hepatitis B Series -18 years and/or younger. Three doses 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-it must have been given within the last 12 months.

- 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 ____/____/____.
- I declare that I will be enrolling in ONLY courses offered by distance learning.

Health Care Provider

Name _____ Signature _____ Date ____/____/____

Address _____ Phone (____) _____