



University Health Center  
 The University of Georgia  
 Athens, GA 30602-1755  
 706-542-8617 Health Information  
 706-542-4959 Fax

Name \_\_\_\_\_  
 UGA ID# \_\_\_\_\_  
 Date of Birth \_\_\_\_\_  
 Phone \_\_\_\_\_

**CERTIFICATE OF IMMUNIZATION (REQUIRED)**

REQUIRED IMMUNIZATIONS	REQUIREMENT	REQUIRED FOR:
MMR (Measles, Mumps, Rubella) combined shot	• 2 Doses #1 _____ / _____ / _____ #2 _____ / _____ / _____	• Students born in 1957 or later
----- OR -----	----- OR -----	-----
• Measles (Rubeola)  and  • Mumps  and  • Rubella (German Measles)	• 2 Doses #1 _____ / _____ / _____ #2 _____ / _____ / _____ • or Titer _____ / _____ / _____ <b>and</b> • 2 Doses #1 _____ / _____ / _____ #2 _____ / _____ / _____ • or Titer _____ / _____ / _____ <b>and</b> • 1 Dose #1 _____ / _____ / _____ • or Titer _____ / _____ / _____	• Students born in 1957 or later   • Students born in 1957 or later   • All students • Attach titer results if done
Varicella (Chicken Pox)	• 2 Doses #1 _____ / _____ / _____ #2 _____ / _____ / _____ • or History of chicken pox or shingles _____ / _____ / _____ • or Titer _____ / _____ / _____	• All <u>U.S. born</u> students born in 1980 or later and all <u>foreign born</u> students regardless of year born  • Attach titer results if done
Tetanus and Diphtheria (Td or Tdap)	• Td _____ / _____ / _____ • or Tdap _____ / _____ / _____	• All students must have one dose within 10 years
Hepatitis B	• 3 Dose series #1 _____ / _____ / _____ #2 _____ / _____ / _____ #3 _____ / _____ / _____	• All students 18 years of age or less at matriculation
Tuberculosis screening	• Must complete TB screening questionnaire, page 2 of this form	• All students. All students, with risk noted, must complete the TB Risk Assessment, page 3 of this form.

**OPTIONAL IMMUNIZATIONS**

Hepatitis A 2 doses	#1 _____ / _____ / _____	#2 _____ / _____ / _____	
Gardasil 3 doses	#1 _____ / _____ / _____	#2 _____ / _____ / _____	#3 _____ / _____ / _____
Meningitis 1 dose	_____ / _____ / _____		
Other vaccines: _____	_____ / _____ / _____	_____ / _____ / _____	

**REQUEST FOR EXEMPTION**

<input type="checkbox"/> Temporary medical exemption until _____ / _____ / _____ Attach verification by doctor	<input type="checkbox"/> Permanent medical exemption Attach verification by doctor	<input type="checkbox"/> Religious exemption Attach verification by religious leader
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**REQUIRED SIGNATURE OF PHYSICIAN OR HEALTH FACILITY**

Name \_\_\_\_\_ Address \_\_\_\_\_  
 Signature \_\_\_\_\_  
 Date \_\_\_\_\_ Phone \_\_\_\_\_

12/08