Georgia Southwestern State University
School of Nursing
CERTIFICATE OF IMMUNIZATION

FNP STUDENT MUST HAVE TITERS. Upload this form to each of the immunization requirements.

STUDENT INFORMATION

Student ID: _____ Date of Birth: _____

Name: (Last)_____(First)_____(Middle)_____

REQUIRED IMMUNIZATION INFORMATION ---**FNP STUDENTS MUST HAVE proof of TITERS- other data optional**

VACCINE	DATE MM/DD/YYYY	DATE MM/DD/YYYY	DATE MM/DD/YYYY		HISTORY	DATE OF POSITIVE LAB/SEROLOGIC EVIDENCE
MMR 1	/	/ /				
Measles 1	/	/ /				/ / titer result
Mumps 1	/	/ /				/ / titer result
Rubella 1	/	/ /				/ / titer result
Varicella 3	/	/ /			(or history of Varicella)	/ / titer result
Tetanus-Diphtheria 4	Tdap /	Td Booster / /				
Hepatitis B 2	/	/ /	/ /		Type Series: ☐ 2 Dose Series ☐ 3 Dose Series	/ / titer result
Hepatitis A 5	/ /	/ /	/ /		Type Series: ☐ 2 Dose Series ☐ 3 Dose Series	/ / titer result
Influenza (most recent date) (Required annually)	/ /					

Tuberculosis Screening Skin Test (Required annually) Date Administered ____/_____/_____

Date Read ____/_____/_____ Results: Positive _____ Negative _____

*If positive the TB Screening Questionnaire and a chest x-ray from a US healthcare facility are required.

1—Not required if born before 1957. 2—Required of all nursing students. 3—Required for all US born students born in 1980 or later; all foreign born students regardless of year born. 4 – Td booster only necessary if > 10 years since Tdap dose. 5---Not required but strongly recommended.

PERMANENT OR TEMPORARY IMMUNIZATION EXEMPTION

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

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

CERTIFICATION OF HEALTH CARE PROVIDER (This information is required)

Signature: _____

Name: _____

Address: _____ Date of Issue: _____/_____/

Telephone: _____

EXEMPTIONS

Check the box, sign, and date if you are claiming exemption of the immunization requirements for the following reason:

☐ I affirm that Immunizations as required by the School of Nursing are in conflict with my religious beliefs. I understand that I am subject to exclusion or actions as required by the specific clinical sites.

Student Signature: _____Date: _____/_____/_____

Revised for FNP: 12/2014 jd