**Georgia Southwestern State University**

**School of Nursing**

**CERTIFICATE OF IMMUNIZATION**

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

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**STUDENT INFORMATION**

Student ID: ___________________________ Date of Birth: ___________________________

Name: (Last) ___________________________ (First) ___________________________ (Middle) ___________________________

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

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>DATE MM/DD/YYYY</th>
<th>DATE MM/DD/YYYY</th>
<th>DATE MM/DD/YYYY</th>
<th>HISTORY</th>
<th>DATE OF POSITIVE LAB/SEROLOGIC EVIDENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMR 1</td>
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<td>/ / titer result</td>
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<tr>
<td>Measles 1</td>
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<tr>
<td>Mumps 1</td>
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<tr>
<td>Rubella 1</td>
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<tr>
<td>Varicella 3</td>
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<td>/ / titer result</td>
</tr>
<tr>
<td>Tetanus-Diphtheria 4</td>
<td></td>
<td>Td Booster</td>
<td></td>
<td></td>
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<td>/ / titer result</td>
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<tr>
<td>Hepatitis B 2</td>
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<td>/ / titer result</td>
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<tr>
<td>Hepatitis A 5</td>
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<td>/ / titer result</td>
</tr>
<tr>
<td>Influenza (most recent date)</td>
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<tr>
<td>(Required annually)</td>
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</tbody>
</table>

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**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.

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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.

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**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: ___________________________

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**CERTIFICATION OF HEALTH CARE PROVIDER (This information is required)**

Signature: ___________________________

Name: ___________________________ Date of Issue: ______/______/_____

Address: ___________________________ Telephone: ___________________________

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**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: ______/______/_____

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Revised for FNP: 12/2014 jd