

**Georgia Southwestern State
University
School of Nursing
CERTIFICATE OF IMMUNIZATION**

*Certificate of Immunization is to be submitted once. Flu and TB requirements are to be completed annually.

STUDENT INFORMATION

Student ID: _____ Date of Birth: _____

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

REQUIRED IMMUNIZATION INFORMATION (See the Immunization Requirements & Recommendations for nursing students)

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

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: ___/___/___