



CERTIFICATE OF IMMUNIZATION

STUDENT HEALTH SERVICES

Note: Keep a copy of this

PART I (to be completed by the student)

Georgia Tech ID# _____ Date of Birth _____ MONTH/DAY/YR

Name _____ LAST FIRST MIDDLE

Address _____ STREET CITY STATE ZIP

Home Country _____

PART II (to be completed and signed by your health care provider)

REQUIRED IMMUNIZATIONS:

A. Measles, Mumps, and Rubella (required for students born in 1957 or later). Health care provider must select item 1, 2, or 3 below, and complete.

1. MMR (Measles, Mumps, and Rubella)

2 doses with the first dose at 12 months or later _____ and the second dose at least 28 days after the first dose _____ OR Laboratory/serologic evidence of immunity

2. Individual immunizations:

a. Measles: 2 doses with the first dose at 12 months or later _____ and the second dose at least 28 days after the first dose _____ OR Laboratory/serologic evidence of immunity

b. Mumps: 1 dose at 12 months or later OR Laboratory/serologic evidence of immunity

c. Rubella: 1 dose at 12 months or later OR Laboratory/serologic evidence of immunity

3. Exemption: Student was born before 1957 and therefore is exempt.

B. Tetanus/Diphtheria (Td booster in the last 10 years or primary series with DTaP, DTP, or Td).

1 Td booster dose within the last 10 years prior to matriculation _____

Completion of primary series (DTaP, DTP, or Td) within the last 10 years prior to matriculation _____

C. Varicella (either a history of chicken pox, a positive Varicella antibody, or 2 doses of vaccine given at least 1 month apart if immunized after age 13)

History of disease OR Laboratory/serologic evidence of immunity OR 1 dose given at 12 months of age or later but before the student's 13th birthday OR 2 doses (dose 1 given after the student's 13th birthday, dose 2 given at least one month after dose 1)

D. Hepatitis B (3 doses of vaccine or a positive Hepatitis surface antibody)

3 doses of Hepatitis B _____ OR

3 doses combined HepA/HepB series _____ OR

2 doses Hepatitis B series of Recombivax _____ OR

Laboratory/serologic evidence of immunity or prior infection

E. Other Immunizations: _____

F. Exemption:

This student is exempt from the above immunization(s) on grounds of permanent medical contraindication.

This student is temporarily exempt from the above immunizations until _____

Health care provider Name _____ Date _____

Address _____ Phone () _____

Signature _____