

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

**FNP STUDENTS: Upload
this form to each of
the immunization
requirements.**

STUDENT INFORMATION

Student ID: _____ Date of Birth: _____

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

REQUIRED IMMUNIZATION INFORMATION ---**Titers required if proof of immunization is not available.**

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: ____/____/____