Albany State University
UNIVERSITY SYSTEM OF GEORGIA

Immunization Form

Office of Admissions and Recruitment
LOCATION • **ADDRESS** 504 College Drive • Albany, GA 31705
PHONE 229.500.4358 • **FAX** 229.500.4946 • **WEB** www.asurams.edu/ student-affairs/health-services

ALL FORMS MUST BE COMPLETED IN ENGLISH

Questions can be emailed to admissions@asurams.edu or you may call us at 229.500.4358.

Date
____/____/____
ACCEPTED TERM/YEAR
_____/_____

NAME ASU STUDENT ID NUMBER

ADDRESS

DATE OF BIRTH AGE PHONE

CERTIFICATE OF IMMUNIZATIONS (REQUIRED)

REQUIRED IMMUNIZATIONS	REQUIREMENT		REQUIRED FOR:
MMR (Measles, Mumps, Rubella) combined shot	• 2 Doses	#1____/____/____ #2____/____/____	• **Students born in 1957 or later and all foreign born students, regardless of year born**
OR		**OR**	
• Measles (Rubella)	• 2 Doses	#1____/____/____ #2____/____/____	• **Students born in 1957 or later** • *Attach titer results with lab values. If antibody titer does not indicate immunity, injection series required.*
	• **or Titer**	____/____/____	
and		**and**	
• Mumps	• 2 Doses	#1____/____/____ #2____/____/____	• **Students born in 1957 or later** • *Attach titer results with lab values. If antibody titer does not indicate immunity, injection series required.*
	• **or Titer**	____/____/____	
		and	
and	• 1 Dose	#1____/____/____	• **Students born in 1957 or later**
• Rubella (German Measles)	• **or Titer**	____/____/____	• *Attach titer results with lab values. If antibody titer does not indicate immunity, injection series required.*
Varicella (Chicken Pox)	• 2 Doses • **or** History of chicken pox (verified by MD) **or** shingles • **or Titer**	#1____/____/____ #2____/____/____ ____/____/____ ____/____/____	• **All *U.S. born* students born in 1980 or later and *all foreign* born students, regardless of year born** • *Attach titer results with lab values. If antibody titer does not indicate immunity, injection series required.*
Tetanus-Diphtheria-Pertussis (Whooping Cough) or Td booster	• Tdap **(Required)** • Td Booster	____/____/____ ____/____/____	• **All students must have one dose of Tdap and One Td booster if it has been ≥10 years after receiving Tdap** *(A single dose of Tdap is recommended to replace a single dose of Td.)*
Hepatitis B	• 3 Dose series • **or Titer**	#1____/____/____ #2____/____/____ #3____/____/____ ____/____/____	• **All students 18 years of age and under at matriculation** • *Attach titer results with lab values. If antibody titer does not indicate immunity, injection series required.*
Tuberculosis screening	• **All students**, must complete TB screening questionnaire		• **If the answer to any of the TB screening questions is "YES", must complete TB Risk Assessment, Part II – to be completed by a physician**

RECOMMENDED IMMUNIZATIONS

Hepatitis A	2 Doses	#1 ____/____/____	#2 ____/____/____	
Human Papillomavirus (HPV-Gardasil)	3 Doses	#1 ____/____/____	#2 ____/____/____	#3 ____/____/____
Meningitis (A, C, Y, W)		#1 ____/____/____	#2 ____/____/____	
Meningitis B	2 or 3 Doses	#1 ____/____/____	#2 ____/____/____	#3 ____/____/____
Other vaccines:	_____	____/____/____	_____	____/____/____

REQUEST FOR EXEMPTION

PERMANENT OR TEMPORARY IMMUNIZATION EXEMPTION (check appropriate area)

❑ This student is exempt from above immunizations on the ground of permanent medical contraindication.

❑ This student is temporarily exempt from the above immunization until_____/_____/_____.

Exemptions and Waivers — In the event of an outbreak, exempted persons may be subject to exclusion from school and to quarantine, until proof of vaccination(s) is provided. If you begin taking courses **"on campus"**, you will no longer be "exempt" and will be required to submit your immunization form.

If religious exemption is required, please sign here — _____
STUDENT SIGNATURE

If you declare that you are enrolling in **ONLY** courses offered by distance learning, please sign here — _____
STUDENT SIGNATURE

If you are living on campus, declining to be immunized against Meningococcal disease, and requesting a wavier for not obtaining the Meningitis vaccine, please sign here — _____ and complete the **Meningococcal Vaccine Declination Form.**
STUDENT SIGNATURE

REQUIRED SIGNATURE OF PHYSICIAN OR HEALTH FACILITY

_____ (_____)_____–_____
NAME PHONE NUMBER

ADDRESS

_____ ____/____/____
SIGNATURE (PHYSICIAN OR HEALTHCARE FACILITY, PLEASE PRINT & SIGN BEFORE SUBMITTING) DATE

PHYSICIAN OR HEALTH FACILITY SIGNATURE IS REQUIRED ON THIS FORM.