

CERTIFICATE OF IMMUNIZATION



Make a copy of this form to keep with your important papers.

As required under University System Policy, this form must be completed and returned to Darton before the student will be eligible for enrollment.

Part A - To be completed by the student (please print).

Name (last, first, middle, Jr., III, etc.)	Expected date of Darton enrollment [] Fall [] Spring [] Summer 20_____
Home Mailing Address	
Sex: (optional) [] Male [] Female	
Date of Birth	Social Security Number
Home Physician	City, State

Part B - To be completed and signed by a health care provider.

REQUIRED IMMUNIZATIONS

I. MMR (Measles, Mumps, Rubella)

1. Dose 1 - Immunized at 12 months of age or later.
 AND (MO/DAY/YR) ___/___/___
 2. Dose 2 - Immunized at least 30 days after dose 1.
 (MO/DAY/YR) ___/___/___

OR

Measles

1. Had disease, confirmed by physician diagnosis in office record.
 OR (MO/YR) ___/___
 2. Has laboratory evidence of immune titer (specify date of titer).
 OR (MO/YR) ___/___
 3. Immunized with live measles at 12 months of age or later.
 AND (MO/DAY/YR) ___/___/___
 4. Immunized with second dose of live measles vaccine at least 30 days
 after first dose. (MO/DAY/YR) ___/___/___

Mumps

1. Had disease, confirmed by physician diagnosis in office record.
 OR (MO/YR) ___/___
 2. Has laboratory evidence of immune titer (specify date of titer).
 OR (MO/YR) ___/___
 3. Immunized with live mumps at 12 months of age or later.
 (MO/DAY/YR) ___/___/___

Rubella

1. Has laboratory evidence of immune titer (specify date of titer).
 OR (MO/YR) ___/___
 2. Immunized with live rubella at 12 months of age or later.
 (MO/YR) ___/___

OR

Exemption

I was born before 1957, and therefore am exempt from the above requirement.

II. Tetanus-Diphtheria

1. One TD booster dose within the last ten years.
 OR (MO/DAY/YR) ___/___/___
 2. Completion of primary series (DTaP, DTP or TD) within the past
 10 years prior to matriculation.
 Completion date (MO/DAY/YR) ___/___/___

III. Varicella - Note: Required for U.S. students born in 1980 or later.
Required for all foreign born students.

1. Had disease, confirmed by health care provider.
 OR (MO/YR) ___/___
 2. Has laboratory evidence of immune titer (specify date of titer).
 OR (MO/YR) ___/___
 3. One dose given at 12 months of age or later but before the student's
 13th birthday. (MO/DAY/YR) ___/___/___
 OR
 4. Two doses. Dose 1 given after the student's 13th birthday; second
 dose one month after first dose.
 (MO/DAY/YR) 1. ___/___/___ 2. ___/___/___

IV. Hepatitis B - Note: Required of all students who are 18 years of age or younger.
(Completion Dates)

1. Three doses hepatitis B series. (MO/DAY/YR) ___/___/___
 OR
 2. Three doses combined hepatitis A and hepatitis B series.
 OR (MO/DAY/YR) ___/___/___
 3. Two doses of hepatitis B series of Recombivax.
 OR (MO/DAY/YR) ___/___/___
 4. Has laboratory evidence of immune titer (specify date of titer).
 (MO/DAY/YR) ___/___/___

OR

Over 18 years of age at matriculation.

Immunization status certified by:

Signature of Health Care Provider Date

Name of Health Care Provider

Address of Health Care Provider

Phone (_____) _____ - _____

MEDICAL EXEMPTION

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

This student is exempt from the above immunizations until ___/___/____. Reason _____

Religious Exemption: I affirm that immunization as required by The University System of Georgia is in conflict with my religious beliefs. I understand that I am subject to exclusion in the event of an outbreak of a disease for which immunization is required.

Distance Learning Exemption: I declare that I will be enrolling in ONLY courses offered by distance learning. I understand that if I register for an on-campus course, this exemption becomes void and I will be excluded from class until I provide proof of immunization.

Signature of Student

Date

Return Form To:

**Office of Admissions
Darton College
2400 Gillionville Road
Albany, GA 31707-3098**