



**CERTIFICATE OF IMMUNIZATION**

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| --- |
| **You may upload the form using the patient portal at clayton.edu/uhs or email the form to** **uhs@clayton.edu** **or fax to 678 466 4944. For any questions, email:** **uhs@clayton.edu** **or call 678 466 4940** |
| Name:  | Laker ID:  |
| Address:  | Date of Birth:  |  |
|  | Phone:  |  |
| **REQUIRED IMMUNIZATIONS** | **REQUIREMENT** | **REQUIRED** |
| **MMR (Measles, Mumps,** **Rubella) combined shot**  | * 2 Doses
 | #1 / #2 /  | / /  | * Students born in 1957 or later
 |
| **OR** |  | **OR** |  |
| * Measles (Rubeola)
 | * 2 Doses
 | #1 /  | /  | * Students born in 1957 or later
 |
|  |  | #2 /  | /  |  |
|  | * **or Titer**
 |  /  | /  |  |
| **and** |  | **and** |  |
| * Mumps
 | * 2 Doses
 | #1 /  | /  | * Students born in 1957 or later
 |
|  |  | #2 /  | /  |  |
|  | * **or Titer**
 |  /  | /  |  |
| **and** |  | **and** |  |
| * Rubella (German Measles)
 | * 1 Dose
 | #1 /  | /  | * **Students born in 1957 or later.**
 |
|  | * **or Titer**
 |  /  | /  | * **Attach titer results.**
 |
| **Varicella (Chicken Pox)** | * 2 Doses
 | #1 /  | /  | * All U.S. born students born in 1980 or later and all foreign born students regardless of year born
* **Attach titer results.**
 |
|  | * **or** History
 | #2 /  | /  |
|  | of chicken |  |  |
|  | pox or |  /  | /  |
|  | shingles* **or** Titer
 |  /  | /  |
| **Tetanus-Diphtheria-Pertussis (Whooping Cough) or Td booster** | * Tdap
* Td Booster
 |  /  /  | / /  | * All students must have one dose of Tdap or 1 dose of Td if it has been 10 years or more since receiving Tdap.
 |
| **Hepatitis B** | * 3 Dose series
 | #1 / #2 / #3 /  | / / /  | * All students 18 years of age and under at matriculation
* **Attach titer results.**
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| **Tuberculosis screening** | * Must complete TB screening questionnaire
 | * All students. All students, with risk noted, must

complete the TB Risk Assessment |

# *STRONGLY RECOMMENDED IMMUNIZATIONS*

|  |  |  |  |
| --- | --- | --- | --- |
| Hepatitis A | 2 Doses | #1 / /  | #2 / /  |
| Human Papillomavirus (HPV) | 3 Doses | #1 / /  | #2 / / #3 / /  |
| Meningitis (A,C,Y,W135) |  | #1 / /  | #2 / /  |
| Meningitis B | 2 or 3 Doses | #1 / /  | #2 / / #3 / /  |
| Influenza  |  \_\_ |  |  |

**CERTIFICATION OF HEALTH CARE PROVIDER (Required) Medical Office Stamp:**

**Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Issue: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Temporary, medical or religious exemption requests require the completion of the Clayton State University Vaccination Exemption Form.**

**Medical certification or notarization requirements apply.**