DALTON STATE COLLEGE

REQUIRED FOR INTERNATIONAL STUDENTS

CERTIFICATE OF IMMUNIZATION

(Return this to the institution)

Return documentation to the college or university that you are applying to. Retain a copy of the completed form for your records.

STUDENT INFORMATION

Student ID_____

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

Address: _____

City: _____State: _____Country: _____Zip Code: _____

Term/Year of Application: _____ Age at time of application: _____ Date of Birth: ____/____/_____

REQUIRED IMMUNIZATION INFORMATION *(See the Immunization Requirements & Recommendations for USG Students documentation)*

VACCINE	DATE MM/DD/YYYY	DATE MM/DD/YYYY	DATE MM/DD/YYYY	HISTORY	DATE OF POSITIVE LAB/SEROLOGIC EVIDENCE
MMR[1]	/ /	/ /			
Measles[1]	/ /	/ /			/ /
Mumps[1]	/ /	/ /			/ /
Rubella[1]	/ /	/ /			/ /
Varicella[3]	/ /	/ /		(or history of Varicella) / /	
Tetanus-Diphtheria Pertussis (Whooping Cough)[4]	/ / Tdap	/ / Td Booster[4]			
Hepatitis B[2]	/ /	/ /	/ /	Type Series: ☐ 2 Dose Series ☐ 3 Dose Series	/ /

1—Not required if born before 1957. 2—Only required of students who are 18 years of age or younger at time of expected matriculation.

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.

PERMANENT OR TEMPORARY IMMUNIZATION EXEMPTION

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

☐ This student is temporarily exempt from the above immunization until ____/____/_____.

CERTIFICATION OF HEALTH CARE PROVIDER *(This information is required)*

Name: _____Signature: _____

Address: _____

Date of Issue: ____/____/_____ Telephone: _____

Student Signature: _____Date: ____/____/_____

DALTON STATE COLLEGE

RECOMMENDED FOR ALL STUDENTS

CERTIFICATE OF IMMUNIZATION

(Return this to the institution)

Return documentation to the college or university that you are applying to. Retain a copy of the completed form for your records.

STUDENT INFORMATION

Student ID_____

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

Address: _____

City: _____State: _____Country: _____Zip Code: _____

Term/Year of Application: _____ Age at time of application: _____ Date of Birth: _____/_____/_____

RECOMMENDED IMMUNIZATION INFORMATION (See the Immunization Requirements & Recommendations for USG Students documentation)

VACCINE	DATE MM/DD/YYYY	DATE MM/DD/YYYY	DATE MM/DD/YYYY	HISTORY	DATE OF POSITIVE LAB/SEROLOGIC EVIDENCE
Human Papillomavirus[5]	/ /	/ /	/ /		
Hepatitis A[6]	/ /	/ /	/ /	Type Series: ☐ 2 Dose Series ☐ 3 Dose Series	/ /
Meningococcal ACWY [7, 8] (MCV4)	/ /	/ / MCV4 Booster[8]			
Meningococcal B[9]	/ /	/ /	/ /	Type Series: ☐ 2 Dose Series ☐ 3 Dose Series	
Annual Influenza[6]	/ /	/ /			

5 – Strongly recommended for all unvaccinated males and females through age 26 years.
6 - Strongly recommended but not required.
7 – Strongly recommended if residing in campus housing, sorority housing, or fraternity housing.
8 – MCV4 Booster necessary if initial MCV4 dose was received more than 5 years prior to admittance.
9 - Consider if younger than 23 yrs of age.

CERTIFICATION OF HEALTH CARE PROVIDER (This information is required)

Name: _____Signature: _____

Address: _____

Date of Issue: _____/_____/_____ Telephone: _____

Student Signature: _____Date: _____/_____/_____