(Revised January 2022)

First for Women WESLEYAN 1836

IMMUNIZATION FORM

(or Georgia Registry of Immunization Transactions and Services "GRITS" Certificate of Immunization)

(Upload with Tuberculosis Form, Physical Exam Form, Health History Form, and Meningitis Verification or Waiver Form to WesPortal's Health Records & Forms page. 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

(All immunizations must be completed or immunity evidenced, as listed below)

VACCINE	DATE MM/DD/YYYY	DATE MM/DD/YYYY	DATE MM/DD/YYYY	HISTORY	DATE OF POSITIVE LAB/SEROLOGIC EVIDENCE
MMR	/ /	/ /			/ /
Measles	/ /	/ /			/ /
Mumps	/ /	/ /			/ /
Rubella	/ /	/ /			/ /
Varicella*	/ /	/ /		(or history of Varicella) / /	
Tetanus-Diphtheria Pertussis (Whooping Cough)	/ / Tdap	/ / Td Booster			
Td booster in last 10 years required if ≥ 10 years since Tdap dose.					
Hepatitis B _*	/ /	/ /	/ /	Type Series: ☐ 2 Dose Series ☐ 3 Dose Series	/ /

***For Varicella and Hepatitis B: a titer lab report is required before starting the Nursing Program**

PERMANENT OR TEMPORARY IMMUNIZATION EXEMPTION

☐ This student is exempt from the following 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: _____

EXEMPTIONS

Check the appropriate box, sign, and date if you are claiming exemption of the immunization requirement for one of the following reasons:

☐ 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.

Student Signature: _____ Date: _____/_____/_____

☐ I declare that I will be enrolling in ONLY courses offered by distance learning. I understand that if 1 register for a course that is offered on-campus or at a campus-managed facility this exemption becomes void and I will be excluded from class until I provide proof of immunization.

Student Signature: _____ Date: _____/_____/_____

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Address: _____

City: _____ State: _____ Country: _____ Zip Code: _____

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

OPTIONAL IMMUNIZATION INFORMATION

(All immunizations on this section below are optional, but please include record if you have it)

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 students through age 26 years.
6 - Strongly recommended but not required.
7 - Strongly recommended if residing in campus 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 must be completed and signed by Healthcare Provider)

Name: _____ Signature _____

Address: _____

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

Student Signature: _____ Date: _____/_____/_____