UNIVERSITY SYSTEM OF GEORGIA

REQUIRED

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: _____

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 I 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: _____/_____/_____

UNIVERSITY SYSTEM OF GEORGIA

RECOMMENDED
CERTIFICATE OF IMMUNIZATION
(Return this to the institution)

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STUDENT INFORMATION

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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: _____/_____/_____

UNIVERSITY of West Georgia.

UNIVERSITY OF WEST GEORGIA

University System of Georgia

HEALTH FORM

Name _____ Date of Birth _____
Last First Middle Initial

Address _____
Street City State Zip

Sex _____ SS# _____ Phone No. _____ Date of Entry at UWG _____

Medical Insurance _____ Policy Number _____

Name of Insured _____ SS# _____

Address of Insurance Co. _____

Is a claim form necessary? _____

PLEASE COMPLETE ALL PORTIONS OF THIS FORM

Permission for Diagnostic and Treatment Procedures

I hereby authorize the physicians of the University Health Service and their agents or consultants, including those at area hospitals, to perform diagnostic and treatment procedures, which in their judgement may become necessary while at West Georgia.

STUDENT SIGNATURE _____ Date _____

PARENT SIGNATURE _____ Date _____

(If student under 18 years of age at time of enrollment) ***With this signature I waive all claim to prior notification. I understand that if, in the judgement of the professional staff, the student's parent or guardian should be notified, this will be done.***

Persons to Notify in an Emergency Situation (preferably close relatives)

1. Name _____ Relationship _____
   Address _____ Office Phone _____
   _____ Home Phone _____
2. Name _____ Relationship _____
   Address _____ Office Phone _____
   _____ Home Phone _____

MEDICAL HISTORY

1. Do you have or have you had any of the following?

Allergies	Yes ❑ No ❑	Diabetes Mellitus	Yes ❑ No ❑	Epilepsy/Convulsions	Yes ❑ No ❑
Asthma	Yes ❑ No ❑	Heart Problems	Yes ❑ No ❑	High Blood Pressure	Yes ❑ No ❑
Do you receive allergy shots?	Yes ❑ No ❑	Periods of Unconsciousness	Yes ❑ No ❑	Rheumatic Fever	Yes ❑ No ❑
Are you allergic to:		Surgical Operations	Yes ❑ No ❑	Tuberculosis	Yes ❑ No ❑
Chicken/Eggs	Yes ❑ No ❑	Hepatitis	Yes ❑ No ❑	Nervous/Emotional Problems	Yes ❑ No ❑
Other Foods	Yes ❑ No ❑	Visual or Hearing Impairment	Yes ❑ No ❑	Learning Disability	Yes ❑ No ❑
Penicillin	Yes ❑ No ❑	Bleeding/Hemophilia	Yes ❑ No ❑	Any Physical Disability	Yes ❑ No ❑
Other Drugs	Yes ❑ No ❑				

2. *IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE PLEASE DESCRIBE BELOW AND HAVE YOUR PHYSICIAN FORWARD A SUMMARY OF YOUR TREATMENT OF ANY CURRENT CONDITION TO CLINICAL DIRECTOR, WEST GEORGIA HEALTH CENTER, CARROLLTON, GA 30118. PLEASE LIST ANY DISABILITIES BECAUSE OF WHICH THE UNIVERSITY MAY NEED TO PROVIDE YOU WITH SPECIAL ASSISTANCE.*

   _____

   _____

3. Do you take any prescribed medication on a regular basis? Yes ❑ No ❑ If yes, please list medications by name.

   _____

4. Tetanus Status: Tetanus Booster Date: _____ (Should have received within past ten years)
5. Have you received the Meningococcal (meningitis) Vaccine: Yes ❑ No ❑
   If Yes, Date of Immunization _____

The information on this form is confidential and will be used only in matters concerning your health. Mail completed form to the appropriate office: Health Services, University of West Georgia, Carrollton, Georgia 30118-4700.

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