



**GEORGIA MILITARY COLLEGE
REQUIRED
CERTIFICATE OF IMMUNIZATION**

Return to: Georgia Military College Health Services
201 E. Greene Street
Milledgeville, GA 31061

Retain a copy of the completed form for your records.

STUDENT INFORMATION

Social Security Number/Student ID: _____ - _____ - _____
 Name: (Last) _____ (First) _____ (Middle) _____
 Address: _____
 City: _____ State: _____ County: _____ Zip Code: _____
 Quarter/Year of Application: _____ Age at time of application: _____ Date of Birth: _____ / _____ / _____

REQUIRED IMMUNIZATION INFORMATION

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	/ /	/ /		(History of Varicella) / /	/ /
Tetanus- Diphtheria\ (DTP, DTaP, Tdap, or Td within 10 years)	(Most recent date) / /				
Hepatitis B ₂	/ /	/ /	/ /	Type Series: <input type="checkbox"/> 2 Dose Series <input type="checkbox"/> 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.

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 Georgia Military College 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: _____ / _____ / _____



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RECOMMENDED IMMUNIZATION INFORMATION

VACCINE	DATE MM/DD/YYYY	DATE MM/DD/YYYY	DATE MM/DD/YYYY	HISTORY	DATE OF POSITIVE LABE/SEROLOGIC EVIDENCE
Human Papillomavirus ₄	/ /	/ /	/ /		
Hepatitis A ₅	/ /	/ /	/ /	Type Series: <input type="checkbox"/> 2 Dose Series <input type="checkbox"/> 3 Dose Series	/ /
Meningococcal ₅	/ /	/ /			
Influenza ₅	/ /	/ /	/ /		

4—Strongly recommended for all unvaccinated women through age 26 years. 5—Strongly recommended but not required.

CERTIFICATION OF HEALTH CARE PROVIDER (This information is required)

Name: _____ Signature: _____
 Address: _____
 Date of Issue: ____/____/____ Telephone: _____

Student Signature: _____ Date: ____/____/____