



# Certification of Immunization & Report of Medical History

## Valdosta State University

### Office of Admissions

ADDRESS 1500 N. Patterson St. • Valdosta, GA 31698-0170

PHONE 229.333.5791 • FAX 229.333.5482 • WEB www.valdosta.edu/admissions

As required under University System Policy, this form must be completed and returned to Valdosta State University before the student will be eligible for enrollment.

#### Part A — To be completed by student (Please Print)

Name \_\_\_\_\_ Expected date of first VSU enrollment \_\_\_\_\_  
LAST FIRST MIDDLE/MAIDEN SEMESTER / YEAR

Date of Birth \_\_\_\_\_ VSU Student ID or Social Security Number \_\_\_\_\_

#### Part B — To be completed and signed by a physician or health department official. Dates must include month and year.

Vaccine	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Date MM/DD/YY	Dates of Positive LAB/SERLOGIC Evidence
<b>MMR</b> (not req. if born before 1957)	/ /	/ /			/ /
<b>Measles</b> (not req. if born before 1957)	/ /	/ /			/ /
<b>Mumps</b> (not req. if born before 1957)	/ /				/ /
<b>Rubella</b> (not req. if born before 1957)	/ /				/ /
<b>Varicella</b> (not req. if born before 1980)	/ /	/ /			(or history of varicella) / /
<b>Tetanus-Diphtheria (DTP, DtaP, or Td)</b> Date must be within 10 years	/ /				
<b>Hepatitis B</b> (Not req. if 19 yrs. of age at time of enrollment)	/ /	/ /	/ /	<b>Type Series</b> <input type="checkbox"/> 2 dose series <input type="checkbox"/> 3 dose series	/ /

#### Part C

Recommended Immunizations — While not required, we recommend that students consider immunization against meningococcal meningitis.

Menomune \_\_\_/\_\_\_/\_\_\_

#### Immunization status indicated above is certified by:

SIGNATURE OF PHYSICIAN OR HEALTH FACILITY OFFICIAL \_\_\_\_\_

DATE \_\_\_\_\_

ADDRESS OF PHYSICIAN OR PUBLIC HEALTH FACILITY \_\_\_\_\_

#### Exemptions

##### Temporary

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

This student is temporarily exempt from the above immunizations until \_\_\_/\_\_\_/\_\_\_.

A. Pregnancy — expected delivery date of \_\_\_/\_\_\_/\_\_\_ B. Other — end date of \_\_\_/\_\_\_/\_\_\_.

##### Permanent

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.

##### Military

Exemption for active duty military or active within the last 2 years (orders or DD-214 required).

STUDENT SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

CONTINUED ON BACK >

**Part D —**

**Directions:** Please complete this portion of the form completely and carefully. It is not necessary to consult a physician for this history. Answer all questions. Information supplied will become part of your Health Record at VSU. It will be held in the strictest confidence, and it will not influence your standing at the University.

**Family History**

Father: Living  Dead  If no longer living, cause of death \_\_\_\_\_  
Mother: Living  Dead  If no longer living, cause of death \_\_\_\_\_  
Brothers & Sisters: Number \_\_\_\_\_ If any have died, cause(s) of death(s): \_\_\_\_\_

Have any of your relatives had any of the following (check appropriate box):

- Diabetes       Tuberculosis       Cancer       Kidney Disease       Heart disease/high blood pressure

Have you ever had or do you now have any of the following (check appropriate box):

- Shortness of breath       Mumps       Scarlet fever       Head Injury  
 Recurrent back pain       Jaundice       Tuberculosis       Rheumatic fever  
 Arthritis       Diabetes Mellitus       Chronic cough       Bleeding/Hemophilia  
 Hay fever       Asthma       Epilepsy or convulsions       Periods of unconsciousness  
 Ear, nose or throat trouble       Stomach, liver or       Paralysis or weakness       Kidney stones or blood in urine

- Infectious mononucleosis       High or low blood pressure  
 Measles       Rubella (German Measles)       Other, please specify: \_\_\_\_\_

Have you received treatment or counseling for emotional problems within 5 years?

- Yes (If yes, attach explanation)       No

Do you know any reason why you should not participate in physical activities?

- Yes (If yes, attach explanation)       No

Has your physical activity been restricted during the past 5 years?

- Yes (If yes, attach explanation)       No

Have you ever been rejected or discharged from the military because of physical, emotional or other reasons?

- Yes       No

Have you ever had an allergic reaction to the following (check only appropriate boxes, if any):

- Penicillin       Sulfa       Eggs or Chicken       Other, please specify \_\_\_\_\_

Have you ever had an operation such as the following (check only appropriate boxes, if any):

- Hernia       Appendectomy       Tonsillectomy       Other, please specify \_\_\_\_\_

**Females Only:** Do you have severe cramps?  Yes  No      Are your periods unusual in interval or flow?  Yes  No

Do you take any medication on a regular basis prescribed by your physician?

- Yes (If yes, describe below)       No

**Permission for Diagnostic and Treatment Procedures**

If you are under 18 years of age, you as well as both your parents or guardians must sign below in the space designated. If you are 18 or older, your signature alone will suffice.

I hereby authorize the physician or the VSU Student Health Services, his agents or consultants, to perform diagnostic and treatment procedures on the student named below. Procedures such as those that may become necessary while he or she is a student at Valdosta State University, and I waive all claim to prior notification. If, in the judgment of the professional staff, the student's parents or guardians should be notified, this will be done. Certainly, in all serious matters, the parents, guardians or spouse will be consulted.

**Signatures**

Student \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian 1. \_\_\_\_\_ Date \_\_\_\_\_ 2. \_\_\_\_\_ Date \_\_\_\_\_

**Persons to Notify in Emergency**

List below two relatives or other persons who may be notified in the event of an emergency situation.

1. Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_  
2. Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

**Note: Students are recommended to keep a copy of this form for future use.**  
**Mail or Return to:** Admissions Office • Valdosta State University • 1500 N. Patterson St. • Valdosta, GA 31698