



Certification of Immunization and Report of Medical History

Admissions Office

Valdosta State University
Valdosta, Georgia 31698
Ph 229-333-5791 • Fax 229-333-5482

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 _____ Social Security Number _____

Part B — To be completed and signed by a physician or health department official.

Dates must include month and year.

Required Immunizations - These immunizations are required by the Board of Regents of the University System of Georgia.

- For students born before 1957, only Part IV - Rubella immunity certification must be completed.
- For all other students either (a) MMR immunity, as in 1, or (b) measles, mumps and rubella as in II, III and IV.

I. MMR (Measles, Mumps, Rubella)

- _____ 1. Dose 1 - immunized at 12 months of age or later AND (MO/YR) _____ / _____
 _____ 2. Dose 2 - immunized at least 30 days after Dose 1 (MO/YR) _____ / _____

II. Measles

- _____ 1. Had disease, confirmed by physician diagnosis in office record OR (MO/YR) _____ / _____
 _____ 2. Born before 1957 and therefore considered immune OR (MO/YR) _____ / _____
 _____ 3. Has laboratory evidence of immune titer (specify date of titer) OR (MO/YR) _____ / _____
 _____ 4. Immunized with live measles at 12 mos. of age or later AND (MO/YR) _____ / _____
 _____ 5. Immunized with second dose of live measles vaccine at least 30 days after first (MO/YR) _____ / _____

III. Mumps

- _____ 1. Had disease, confirmed by physician diagnosis in office record OR (MO/YR) _____ / _____
 _____ 2. Born before 1957 and therefore considered immune OR (MO/YR) _____ / _____
 _____ 3. Has laboratory evidence of immune titer (specify date of titer) OR (MO/YR) _____ / _____
 _____ 4. Immunized with vaccine at 12 mos. of age or later (MO/YR) _____ / _____

IV. Rubella

- _____ 1. Has laboratory evidence of immune titer (specify date of titer) OR (MO/YR) _____ / _____
 _____ 2. Immunized with vaccine at 12 mos. of age or later (MO/YR) _____ / _____

V. TETANUS (dT) – Booster is required within last 10 years (MO/YR) _____ / _____

VI. HEPATITIS B – Required for all students who will be under 19 years of age at the time of enrollment.

Dose 1 ___/___/___ Dose 2 ___/___/___ Dose 3 ___/___/___

VII. Varicella (Chickenpox)

Vaccine Dose 1 ___/___/___ Dose 2 ___/___/___ or Active Disease ___/___/___

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

NAME OF PHYSICIAN OR PUBLIC HEALTH FACILITY

ADDRESS OF PHYSICIAN OR PUBLIC HEALTH FACILITY

Exemptions:

- _____ Exemption on grounds of permanent medical contraindication
 _____ Exemption on grounds of temporary medical contraindication
 A. Pregnancy, expected delivery date: ___/___/___
 B. Other, anticipated date of contraindication's end: ___/___/___
 _____ Religious exemption: I affirm that immunization as required by The University System of Georgia is in conflict with my religious beliefs.

I understand that exemption for any of the reasons listed above subjects me to exclusion in the event of an outbreak of a disease for which immunization is required.

SIGNATURE OF STUDENT REQUIRED ONLY FOR EXEMPTIONS DATE

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):

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Mumps | <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Head Injury |
| <input type="checkbox"/> Recurrent back pain | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Bleeding/Hemophilia |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy or convulsions | <input type="checkbox"/> Periods of unconsciousness |
| <input type="checkbox"/> Ear, nose or throat trouble | <input type="checkbox"/> Stomach, liver or intestinal trouble | <input type="checkbox"/> Paralysis or weakness | <input type="checkbox"/> Kidney stones or blood in urine |
| <input type="checkbox"/> Infectious mononucleosis | <input type="checkbox"/> High or low blood pressure | | |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Rubella (German Measles) | <input type="checkbox"/> 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 • Valdosta, Georgia 31698