

**Return Form To:
 ABAC Health Center
 ABAC 52; 2802 Moore Hwy
 Tifton, GA 31793-2601
 Fax Number: (229) 391-5031**

Make a copy of this form to keep with your important papers.

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

Part A – To be completed by the student (please print).

Name (last, first, middle, Jr., III, etc.) _____ Expected date [] Fall [] Spring of ABAC enrollment [] Summer 20 _____

Home Phone Area Code _____ Number _____

Home Mailing Address _____ City _____ State _____ Zip _____

Sex: Male Female Date of Birth _____ ABAC ID Number _____

Home Physician Address _____ City, State Zip _____ Phone Area Code _____ Number _____

Part B – To be completed and signed by a health care provider.

REQUIRED IMMUNIZATIONS

I. MMR (Measles, Mumps, Rubella)

____ 1. Dose 1 – Immunized at 12 months of age or later
 AND (MO/DAY/YR) ____/____/____
 ____ 2. Dose 2 – Immunized at least 30 days after dose 1
 (MO/DAY/YR) ____/____/____

OR

Measles

____ 1. Had disease, confirmed by physician diagnosis in office record,
 OR (MO/YR) ____/____/____
 ____ 2. Has laboratory evidence of immune titer (specify date of titer)
 OR (MO/YR) ____/____/____
 ____ 3. Immunized with live measles at 12 months of age or later.
 2nd dose of live measles at least 28 days after 1st dose.
 (MO/DAY/YR) ____/____/____
 (MO/DAY/YR) ____/____/____

Mumps

____ 1. Had disease, confirmed by physician diagnosis in office record,
 OR (MO/YR) ____/____/____
 ____ 2. Has laboratory evidence of immune titer (specify date of titer)
 OR (MO/YR) ____/____/____
 ____ 3. Immunized with live mumps at 12 months of age or later.
 2nd dose of live mumps at least 28 days after 1st dose.
 (MO/DAY/YR) ____/____/____
 (MO/DAY/YR) ____/____/____

Rubella

____ 1. Has laboratory evidence of immune titer (specify date of titer)
 OR (MO/YR) ____/____/____
 ____ 2. Immunized with live rubella at 12 months of age or later
 (MO/YR) ____/____/____

OR

Exemption

____ I was born before 1957, and therefore am exempt from the above requirement.

II. Tetanus-Diphtheria-Pertussis

____ 1. One Tdap within ten years
 OR (MO/DAY/YR) ____/____/____
 ____ 2. One Td within ten years
 (MO/DAY/YR) ____/____/____
 AND history one Tdap (MO/DAY/YR) ____/____/____

III. Varicella (For student born in 1980 or later and all foreign born students, regardless of age.)

____ 1. Had disease, confirmed by health care provider,
 OR (MO/YR) ____/____/____
 ____ 2. Has laboratory evidence of immune titer (specify date of titer)
 OR (MO/YR) ____/____/____
 ____ 3. Two doses. Dose 1 given after the student's 1st birthday; 2nd
 dose at least 28 days after 1st dose.
 (MO/DAY/YR) (1) ____/____/____ (2) ____/____/____
 OR
 ____ 4. History of shingles (herpes zoster)
 (MO/YR) ____/____/____
 OR

Exemption

____ 5. I was born in the US before 1980, and am therefore exempt from the above requirement

IV. Hepatitis B – Note – required of all students who are 18 years of age or younger.

____ 1. Three doses hepatitis B series
 (MO/DAY/YR)
 1) ____/____/____ 2) ____/____/____ 3) ____/____/____
 OR
 ____ 2. Two doses of Recombivax if given between 11 and 15 years of age.
 (MO/DAY/YR) 1) ____/____/____ 2) ____/____/____
 OR
 ____ 3. Has laboratory evidence of immune titer (specify date of titer)
 ____/____/____ OR
 ____ Nineteen (19) years of age or over at matriculation.

Immunization status to this date certified by:

 Signature of Health Care Provider Date

 Name of Health Care Provider

 Address of Health Care Provider
 Phone (____) _____ - _____

EXEMPTIONS

[] **Military Exemption:** Member of the military within the last two years may be validated as having met the immunization requirement with proof of active military service (copy of DD214). Complete Part A above and attach documentation.

Medical Exemption

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

[] This student is exempt from the above immunizations until ____/____/____. Reason _____

[] **Religious Exemption:** 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.

 Signature of Student (Student signature required only for Religious Exemption) Date