UNIVERSITY SYSTEM OF GEORGIA

RECOMMENDED
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: __ / __ / ______

RECOMMENDED IMMUNIZATION INFORMATION (See the Immunization Requirements & Recommendations for USG Students documentation)

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>DATE MM/DD/YYYY</th>
<th>DATE MM/DD/YYYY</th>
<th>DATE MM/DD/YYYY</th>
<th>HISTORY</th>
<th>DATE OF POSITIVE LAB/SEROLOGIC EVIDENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human Papillomavirus</td>
<td></td>
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</tbody>
</table>
| Hepatitis A              |                 |                 |                 | Type Series: | 2 Dose Series  
|                          |                 |                 |                 | □ 3 Dose Series | / / |
| Meningococcal ACWY      |                 |                 |                 |         |                                        |
| (MCV4)                   |                 |                 |                 | Type Series: | 2 Dose Series  
|                          |                 |                 |                 | □ 3 Dose Series | / / |
| Meningococcal B          |                 |                 |                 |         |                                        |
| Annual Influenza         |                 |                 |                 |         |                                        |

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: _____ / ____ / ______

(Revision – January 2016- PG 2 of 2)