BERRY COLLEGE

Health and Wellness Center

IMMUNIZATION RECORD

Name_____ Social Security Number_____

Date of Birth _____/_____/_____ Semester and year entering Berry _____

All information below is to be completed by a <u>Health Care Provider</u> (*Dates MUST include month and Year*) :

Required Immunizations—*Students will not be permitted to register until this information is on file in Health Services.*

	MO YEAR
A. **<u>MMR</u>** (*Measles, Mumps, Rubella*) ***Note: Date must be after 1970***	
1. Dose 1—Immunized at 12 months of age or later, and	_____/_____
2. Dose 2—Immunized at least 30 days after dose 1	_____/_____
OR	
B. **<u>MEASLES</u>** (*Rubeola*) ***Note: Date must be after March 4, 1963***	
1. Had disease confirmed by physician diagnosis in office record, OR	_____/_____
2. Born before 1957 and therefore considered immune, OR	_____/_____
3. Has laboratory evidence of immune titer (specify date of titer) OR	_____/_____
4. Immunized with live measles vaccine at 12 mos. of age or later, AND	_____/_____
5. Immunized with second dose of live measles vaccine at least 30 days after first dose	_____/_____
AND	
C. **<u>MUMPS</u>** ***Note: Date must be after April 22, 1971***	
1. Had disease confirmed by physician diagnosis in office record, OR	_____/_____
2. Born before 1957 and therefore considered immune, OR	_____/_____
3. Has laboratory evidence of immune titer (specify date of titer) OR	_____/_____
4. Immunized with live measles vaccine at 12 mos. of age or later	_____/_____
AND	
D. **<u>RUBELLA</u>** ***Note: Date must be after June 9, 1969***	
1. Has laboratory evidence of immune titer (specify date of titer) OR	_____/_____
2. Immunized with live measles vaccine at 12 mos. of age or later	_____/_____

Other Required Immunizations—*Students will not be permitted to reside on campus until this information is on file in Health Services.*

<u>MENINGOCOCCAL MENINGITIS</u> _____/_____

Note: This vaccine is recommended, but not required, for non-resident students.

Recommended Immunizations*—Though not required, we recommend that students consider immunizations against Hepatitis B, Tetanus/Diptheria, and Influenza.*

Tetanus/Diptheria ____/____/_____ **TB Skin Test** (*Within 12 months, if positive, include date of chest X-ray*) ____/____/____

Hepatitis Dose 1 ____/____/_____ **Hepatitis Dose 2** ____/____/_____ **Hepatitis Dose 3** ____/____/_____

Immunization status indicated above is certified by:

Signature:_____ **Date**:_____

Name and Address of 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 from campus in the event of an outbreak of a disease for which immunization is required.

Signature of Student:_____Date: ____/____/_____