University Health Center
Student Affairs
UNIVERSITY OF GEORGIA

UNIVERSITY HEALTH CENTER
University of Georgia
Athens, GA 30602-1755
Phone: 706-542-1162
Fax : 888-218-9658

NAME: _____

UGA ID#: _____

DATE OF BIRTH: _____

CERTIFICATE OF IMMUNIZATION

This form is required prior to registering for classes. A Healthcare ***Provider signature is NOT required if attaching GRITS or other certified immunization record.***

Requirements					
	1st Injection MM/DD/YYYY	**2nd Injection MM/DD/YYYY**	**3rd Injection MM/DD/YYYY**	OR	**Titer Confirming Immunity**
MMR (Measles, Mumps, Rubella)* 2 doses at least 28 days apart ***Not required if born before 1957** OR **Measles** + **Mumps** + **Rubella**	__/__/____	__/__/____			
	__/__/____	__/__/____		OR	Attach Lab Report in English
	__/__/____	__/__/____		OR	Attach Lab Report in English
	__/__/____			OR	Attach in Lab Report in English
Varicella (Chicken Pox)* 2 doses at least 28 days apart ***Not required if born before 1980 in the USA**	__/__/____	__/__/____	**OR** History of Disease: Attach verification statement from healthcare provider	OR	Attach Lab Report in English
Tdap (Tetanus, Diphtheria, Pertussis) 1 initial dose then 1 Td or Tdap every 10 years	__/__/____	__/__/____	**OR** if unable to obtain in home country, obtain at UGA upon arrival to campus		
Hepatitis B* 2-dose series at 0 and 4-6 months **or** 3-dose series at 0, 1-2, and 4-6 months ***Only required for those ages 18 or younger**	__/__/____	__/__/____	__/__/____	OR	Attach Lab Report in English
Tuberculosis (TB) Screening	All students must complete Part I Tuberculosis (TB) Screening Questionnaire. If screening Yes to any question in Part I, then complete Parts II & III with healthcare provider.			OR	Attach Letter of LTBI Treatment Completion or Declination in English
Recommendations					
Meningococcal ACWY* ***Recommended** if an Incoming Freshman or planning to reside in Campus or Greek Housing	__/__/____	__/__/____	❑ Menactra ❑ Menveo		
Meningococcal B	__/__/____	__/__/____	__/__/____	❑ Bexsero ❑ Trumenba	
Hepatitis A	__/__/____	__/__/____	__/__/____		
Human Papillomavirus (HPV)	__/__/____	__/__/____	__/__/____		
Influenza	__/__/____				
COVID	__/__/____	__/__/____	__/__/____		

❑ **Request for Religious Exemption** (attach Notarized Affidavit signed by student and no older than 6 months): I affirm that the immunizations required by the University System of Georgia conflict with my religious beliefs. I understand I am subject to exclusion from campus in the event of an outbreak of disease of which immunization is required.

❑ **Request for Permanent Medical Contraindication** (attach Verification from Healthcare Provider)

Signature of Healthcare Provider and Date Required

Name: _____ Address: _____

Signature: _____ Date: _____ Phone: _____

Form Reviewed: 3/17; 3/18; 7/21; 5/24; 5/25; 5/26
Form Revised: 3/2016; 5/22; 5/25; 5/26

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PART I: Tuberculosis (TB) Screening Questionnaire (REQUIRED for all students)

1. Have you ever had close contact with anyone known or suspected to have active TB disease? ❑Yes ❑ No
2. Were you born in one of the **countries listed below** that have a high incidence of active TB disease? (**If Yes**, circle country) ❑Yes ❑ No
3. Have you resided in or traveled to **one or more of the countries listed below** for a cumulative period of 1 month or more? ❑Yes ❑ No (**If Yes**, circle countries. If yes to questions #2 or #3, what was date of last travel? _____
4. Have you been a resident, volunteer, and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? ❑Yes ❑ No
5. Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease? ❑Yes ❑ No
6. Have you ever been a member of any of the following groups that may have an increased incidence of inactive TB infection or active TB disease: medically underserved, low-income, or using drugs or alcohol? ❑Yes ❑ No

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
Central African Republic Chad
China
China, Hong Kong SAR
China, Macao SAR
Colombia
Comoros
Congo
Congo (Democratic Republic of)
Cote d'Ivoire
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Eswatini
Ethiopia
Fiji
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Kazakhstan
Kenya
Kiribati
Kyrgyzstan
Laos
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mexico
Micronesia
Moldova
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Niue
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Qatar
Romania
Russia
Rwanda
Sao Tome and Principe
Senegal Sierra
Leone Singapore
Solomon Islands
Somalia
South Africa
South Korea
South Sudan
Sri Lanka
Sudan
Suriname
Tajikistan
Tanzania
Thailand
Timor-Leste
Togo
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
Uruguay
Uzbekistan
Vanuatu
Venezuela
Vietnam
Yemen
Zambia
Zimbabwe

Source: American College Health Association (2025, April). *ACHA Guidelines: Tuberculosis Risk Assessment and Management*.

If you answered YES to <u>any</u> of the above questions, then the University of Georgia requires that you complete **Part II** with a healthcare provider. The significance of any travel exposure should be reviewed with a healthcare provider.

If the answer to all questions above is NO, then no further testing or action is required. Do not proceed to Part II.

Signature of Student (or Guardian if under 18): _____ Date: _____

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PART II. Clinical Assessment by Healthcare Provider (REQUIRED if Yes to any questions in Part I)

The healthcare provider should verify the information in **Part I**. Persons answering Yes to any of the questions in **Part I** should complete testing in **Part II** unless a previous Positive test has been documented.

1. **History of a positive TB skin test or IGRA blood test?** (If yes, document in #4) ❑Yes ❑ No
2. **History of BCG vaccination?** (If yes, obtain IGRA blood test instead of TST) ❑Yes ❑ No
3. **Does the student have signs or symptoms of active pulmonary tuberculosis disease?** ❑Yes ❑ No
   a. **If No,** proceed to #4. **If Yes,** indicate symptoms and proceed with evaluation to exclude active TB disease:

❑Cough lasting for 3 weeks or longer with or without sputum	❑Chest pain	❑Unexplained weight loss	❑Fevers
	❑Coughing up blood	❑Loss of appetite	❑Night sweats

4. **Tuberculosis (TB) Testing**

If Positive, proceed with #5 and Part III. **If Negative**, then no further testing or action is required.

Tuberculin Skin Test (TST)	OR	**Interferon Gamma Release Assay (IGRA) blood test** Recommended for persons with history of BCG vaccination
Dated Placed (MM/DD/YYYY): ___ / ___ / ____ Date Read (MM/DD/YYYY): ___ / ___ / ____		Dated Obtained (MM/DD/YYYY): ___ / ___ / ____ Specify Test: ❑ QFT-GIT ❑ T-Spot ❑ Other: _____
Result: _____ mm of induration Interpretation: ❑ Positive ❑ Negative		Result: ❑ Positive ❑ Negative ❑ Indeterminate ❑ Borderline (T-spot only)
Name & Signature of Healthcare Provider:		Name & Signature of Healthcare Provider:

5. **Chest X-Ray** (required if Positive result in #4)
   Date of CXR (MM/DD/YYYY): ___ / ___ / ____
   Result: ❑ Normal ❑ Abnormal
   a. Name & Signature of Health Care Provider: _____

PART III: Management of TST or IGRA Results (REQUIRED if Positive in Part II)

All students with a Positive TST or IGRA with no signs of active disease on chest x-ray should receive a recommendation from their healthcare provider to be treated for latent tuberculosis (LTBI). For management of Positive TST or IGRA, refer to **www.cdc.gov/tb**.

_____ Student agrees to begin treatment OR _____ Student declines to begin treatment at this time

Signature of Healthcare Provider and Date Required

Name: _____ Address: _____

Signature: _____ Date: _____ Phone: _____

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