CLAYTON STATE
UNIVERSITY

CERTIFICATE OF IMMUNIZATION

Upload this form in the Supplemental Forms Section of your application portal at apply.clayton.edu, email to HWC@clayton.edu, or fax to 770-968-3534. For any questions, email: HWC@clayton.edu or call 678-466-4940.

Name: ______________________________

Address: ______________________________ Date of Birth: ____________________

______________________________ Phone: ____________________

REQUIRED IMMUNIZATIONS	REQUIREMENT	REQUIRED
MMR (Measles, Mumps, Rubella) combined shot	•2 Doses #1____/____/____ #2____/____/____	• Students born in 1957 or later
OR	**OR**	
•Measles (Rubeola)	•2 Doses #1____/____/____ #2____/____/____ **•or Titer** ____/____/____	• Students born in 1957 or later
and	**and**	
•Mumps	•2 Doses #1____/____/____ #2____/____/____ **•or Titer** ____/____/____	• Students born in 1957 or later
and	**and**	
•Rubella (German Measles)	•1 Dose #1____/____/____ **•or Titer** ____/____/____	**• Students born in 1957 or later.** **• Attach titer results.**
Varicella (Chicken Pox)	•2 Doses #1____/____/____ #2____/____/____ **•or** History of chicken pox or shingles ____/____/____ **•or** Titer ____/____/____	• All U.S. born students born in 1980 or later and all foreign born students regardless of year born **•Attach titer results.**
Tetanus-Diphtheria-Pertussis (Whooping Cough) or Td booster	•Tdap ____/____/____ •Td Booster ____/____/____	• All students must have one dose of Tdap or 1 dose of Td if it has been 10 years or more since receiving Tdap.
Hepatitis B	•3 Dose series #1____/____/____ #2____/____/____ #3____/____/____	•All students 18 years of age and under at matriculation **• Attach titer results.**
Tuberculosis screening	•Must complete TB screening questionnaire	•All students. All students, with risk noted, must complete the TB Risk Assessment

STRONGLY RECOMMENDED IMMUNIZATIONS

Hepatitis A	2 Doses	#1____/____/____	#2____/____/____
Human Papillomavirus (HPV)	3 Doses	#1____/____/____	#2____/____/____ #3____/____/____
Meningitis (A,C,Y,W135)		#1____/____/____	#2____/____/____
Meningitis B	2 or 3 Doses	#1____/____/____	#2____/____/____ #3____/____/____
Influenza		____________ __	

CERTIFICATION OF HEALTH CARE PROVIDER (Required)

Medical Office Stamp:

Printed Name: ______________________________

Address: ______________________________

Date of Issue: ____________________

Signature: ______________________________

Temporary, medical or religious exemption requests require the completion of the Clayton State University Vaccination Exemption Form. Medical certification or notarization requirements apply.