It is important that applicants begin immediately to gather the information listed below since proof of immunization may require obtaining records, or making appointments with a physician / health care agency. Retain a copy of the completed form for your records.

Return Certificate of Immunization to:  
Atlanta Metropolitan College, Office of Admissions  
1630 Metropolitan Parkway, S.W., Atlanta, Georgia 30310

**STUDENT INFORMATION**

Name: (Last) _______________________________________ (First) ____________________________________ (Middle) ______________ ________  
Address: _____________________________________________________________________________________________  
City: __________________________  State:  _____  County:  ____________________ Zip Code:  _______________  
Term/Year of Application:  ____________________ Age at time of application:  ________  Date of birth: _______________  

**REQUIRED IMMUNIZATIONS**

TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER  
Please fill in month, date, and year immunization was given in the space provided.

A. **Measles, Mumps, Rubella** (Required for applicants born in 1957 or later)

   1. **M.M.R.**
      
      ___ /___/___  Two (2) doses with the first dose at 12 months of age or later and the second at least 28 days after the first dose, **OR**  
      ___ /___/___  Laboratory/serologic evidence of immunity **OR**  

      **Measles**
      
      ___ /___/___  Two (2) doses of live measles containing vaccine (combined measles-mumps-rubella or MMR meets this requirement) with first dose at 12 months of age or later and the second at least 28 days after the first dose, **OR**  
      ___ /___/___  Laboratory/serologic evidence of immunity **OR**  

      **Mumps**
      
      ___ /___/___  Two (2) doses of live mumps containing vaccine (combined measles-mumps-rubella or MMR meets this requirement) with first dose at 12 months of age or later and the second at least 28 days after the first dose, **OR**  
      ___ /___/___  Laboratory/serologic evidence of immunity **OR**  

      **Rubella**
      
      ___ /___/___  One (1) dose at 12 months of age or later (MMR meets this requirement), **OR**  
      ___ /___/___  Laboratory/serologic evidence of immunity **OR**  

   **Required of applicants born before 1957**

B. **Tetanus-Diphtheria** (TD containing booster dose within 10 years prior to matriculation) or (a Primary Series with DTaP, DTP, or Td)

   ___ /___/___ One (1) TD booster dose within the last ten years prior to matriculation, **OR**  
   ___ /___/___ Completion of primary series (DTaP, DTP or TD) within 10 years prior to matriculation

C. **Varicella** (Either a positive varicella (chicken pox) antibody, or two (2) doses of vaccine given at least three months apart, if immunized after age 13 years, or a history date for chicken pox.)

   ___ /___/___ Two (2) doses at least 4 weeks apart if first dose given after the student’s 13th birthday. **OR**  
   ___ /___/___ Reliable history of disease? Yes ___ No ____  **OR**  
   ___ /___/___ History of herpes zoster (shingles), **OR**  
   ___ /___/___ Laboratory/serologic evidence of immunity **OR**  

D. **Hepatitis B** – Required of all students who are 18 years of age or younger at matriculation.

   ___ /___/___ Three–dose Hepatitis B series, **OR**  
   ___ /___/___ Three–dose combined Hepatitis A and Hepatitis B series, **OR**  
   ___ /___/___ Two doses Hepatitis B series of Recombivax, **OR**  
   ___ /___/___ Laboratory/serologic evidence of immunity or prior infections

E. **Permanent or Temporary Immunization Exemption** (Please Check)

   ___   This student is exempt from the above immunizations on grounds of permanent medical contraindication  
   ___   This student is temporarily exempt from the above immunizations until ___/___/_____

**CERTIFICATION OF HEALTH CARE PROVIDER** (This information is required)  

Name: _____________________________________________ Signature: _______________________________________________  
Address: _________________________________________________________________________________________________________  
Date of Issue: __________________________________ Telephone: __________________________________

**EXEMPTIONS**

Check the appropriate box, sign, and date if you are claiming exemption of the immunization requirement for one of the following:

_____   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.  
_____   I declare that I will be enrolling in ONLY courses offered in distance learning. I understand that if I register for a course that is offered on-campus or at a campus managed facility this exemption becomes void and I will be excluded from class until I provide proof of immunization.

Student Signature: ___________________________________________________________ Date: ___________________________