GEORGIA SOUTHERN UNIVERSITY  
SCHOOL OF NURSING  
IMMUNIZATION FORM

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<tr>
<th>Student Name</th>
<th>Date of Birth</th>
<th>Eagle ID #</th>
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School of Nursing Required Immunizations or Tests:  
(Must be completed prior to enrollment in the first nursing course)

A. **TB Test: Quantiferon TB Gold In-Tube (QFT-GIT)**
   Date: ___________________________  Result: ___________________________
   Provider: _________________________

B. **Hepatitis B**
   Dose #1 Date: ___________  Provider Initials: ___________  Agency: ___________
   Dose #2 Date: ___________  Provider Initials: ___________  Agency: ___________
   Dose #3 Date: ___________  Provider Initials: ___________  Agency: ___________
   Or Immune Titer Date: ___________  Result: ___________________________
   Or Vaccine Refusal Date: ___________  Attach Form
   Waiver Form for Incomplete Series Date: ___________  Attach Form

C. **MMR (Measles, Mumps, Rubella) Booster**, if born after 1957 or laboratory evidence of immunity to measles and rubella:
   Dose 1 - immunized at 12 months of age or later  Date: ___________________________
   Dose 2 - immunized at least 30 days after Dose 1  Date: ___________________________

D. **Tdap (Tetanus, Diphtheria, and Pertussis)** required UNLESS evidence* of receiving a Tdap at age 11 or older (*attach GRITS or other form)  Date: ___________________________

E. **Seasonal Flu Vaccine**
   Date: ___________________________

F. **Varicella**
   ___ I have had a varicella titer; Date and results: ___________________________
   Or ___ I have been immunized against chicken pox. Varicella vaccine x2 doses:
   Date: ___________________________
   Date: ___________________________

Print or type name and address of health care provider completing this form.

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<tr>
<th>Name</th>
<th>Address</th>
<th>Title</th>
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City or Town  State  Zip  Phone

Immunization status above is certified by:

_________________________  Date Signed

Signature of Health Care Provider