UNG UNIVERSITY of NORTH GEORGIA
DEPARTMENT OF PHYSICAL THERAPY

University of North Georgia
Certificate of Immunization for
Doctorate of Physical Therapy Applicants

Make a copy of this completed form for your records and send the form to the address below **after April 3, 2020, but before May 8, 2020.** This form must be fully completed. Dates are required for all applicable immunizations.
For students accepted into the t-DPT program forms are due after June 26, 2020 but before July 31, 2020.

STUDENT INFORMATION:

Name (Last) _____ (First) _____ (MI) _____

Date of Birth ____/____/_____ Term of Application _____

IMMUNIZATION INFORMATION (DATES ARE REQUIRED)

VACCINE	DATE MM/DD/YYYY	DATE MM/DD/YYYY	DATE MM/DD/YYYY		DATE OF POSITIVE LAB/SEROLOGIC EVIDENCE
MMR [1] or	/ /	/ /			
Measles	/ /	/ /			/ /
Mumps	/ /	/ /			/ /
Rubella	/ /	/ /			/ /
Varicella [2](chicken pox)	/ /	/ /			(or history of) / /
Tetanus-Diptheria (DTP, DTaP, Tdap, or Td) **Within 10 years**	Most recent date / /				
Hepatitis B Series/Titer ___ 2 Dose Series ___ 3 Dose Series	/ /	/ /	/ /	Date of Titer / /	**Titer Result:** Positive Negative
PPD (Mantoux Skin Test Required!)[3]	/ /				
Strongly Recommended Meningococcal Vaccine[4]	/ /				

1. Not required if born before 1957.
2. Not required if born in the US before 1980.
3. PPD must be administered no more than 3 months prior to start of class. Repeat testing required annually. If you have a positive PPD, a chest x-ray and completion of the Positive PPD Questionnaire are required.
4. Meningococcal (strongly recommended) – l dose meningococcal conjugate vaccine (preferred) or 1 dose of meningococcal polysaccharide within 5 years prior to matriculation or signed document that student has received and reviewed information about the disease as required by O.C.G.A. §31-12-3.2.

PERMANENT OR TEMPORARY IMMUNIZATION EXEMPTION

☐ This student is exempt from the above immunizations on the ground of permanent medical contraindication.
☐ This student is temporarily exempt from the above immunization until _____/____/_____.

CERTIFICATION OF HEALTH CARE PROVIDER (REQUIRED)

_____
Name of health care provider

_____ _____ _____
Address of health care provider Signature of physician or health care provider Date

Mail, Fax, or eMail:

University of North Georgia
Student Health Services
82 College Circle
Dahlonega, GA 30597

Fax: (706) 864-1948
Email:stuhealth@ung.edu

If you need this document in another format, please email LYoungblood@ung.edu or call (706) 864-1863