

San Francisco State University IMMUNIZATION REQUIREMENTS

All students must provide proof of immunization before they may register for classes.

Note: Students who were enrolled in a California public school for the seventh grade or higher on or after July 1, 1999 DO NOT have to complete and submit this form to provide proof of immunization against Measles, Rubella and Hepatitis B BUT students are advised to do so as the requirements may change in the very near future.

LAST NAME _____ FIRST NAME _____ M.I. _____
 ADDRESS _____
 PHONE NUMBER(S) _____ DATE OF BIRTH _____
 STUDENT ID # _____ E-MAIL _____ MAJOR _____

**Please complete the rest of this form
Or attach copies of your immunization records**

Mail or bring this form in person to:	Questions?
<p>Registrar's Office, SSB 101 San Francisco State University 1600 Holloway Avenue San Francisco, CA 94132</p>	<p>Registrar, One Stop Student Service Center, SSB 101 Phone: 415-338-2350 FAX: 415-338-0588 http://www.sfsu.edu/~shs/Immunizations/Required Imm.html</p>
<p>ALL STUDENTS* born after 1957</p> <p>Measles, Mumps, Rubella (MMR) Vaccine</p> <p>Date of immunization #1 _____ Date of Immunization #2 _____</p> <p style="text-align: center;">OR</p> <p>Results of a blood test indicating immunity _____ Date of blood test _____ Results _____</p> <p><small>If you were born before 1957, check with your academic department to see if immunizations are needed for curriculum requirements eg. Enrolled in Dietetics, Medical Technology, Nursing, Physical Therapy or any Practicum, Student Teaching or Field Work involving Pre-School Children or taking place in a Hospital or Health Care Setting.</small></p> <p>----- CERTIFICATION BY MD / RN -----</p> <p>Name _____ Address _____ Date _____ Office Stamp _____</p>	<p>STUDENTS 18 YEARS OR YOUNGER</p> <p>Hepatitis B Vaccine</p> <p>Date of dose #1 _____ Date of dose #2 _____ Date of dose #3 _____</p> <p style="text-align: center;">OR</p> <p>Results of a blood test indicating immunity _____ Date of blood test _____ Test performed _____ Results _____</p> <p style="color: blue;">Also NEED Proof of MMR Vaccination – See Previous Column</p> <p>----- CERTIFICATION BY MD / RN -----</p> <p>Name _____ Address _____ Date _____ Office Stamp _____</p>

WAIVER/EXEMPTIONS MMR/HEP B - Please contact the Registrar's Office for details:
 Registrar's Office, SSB 101, 1600 Holloway Avenue, San Francisco, CA 94132, Tel: 415-338-2350 Fax: 415-338-0588

For Additional Information On Recommended Vaccines
 See: <http://www.cdc.gov/vaccines/recs/schedules/teen-schedule.htm>

DO NOT SUBMIT ORIGINAL DOCUMENTS. PLEASE BRING A COPY OF ALL DOCUMENTS TO CAMPUS.