San Francisco State University - IMMUNIZATION REQUIREMENTS (CSU EO 803)

All students must provide proof of immunization before they may register for classes. The SHS recommends that students keep up to date with all recommended vaccinations.

http://www.cdc.gov/vaccines/adults/rec-vac/index.html

Note: Students who were enrolled in a California public school for the seventh grade or higher on or after July 1, 1999

DO NOT currently 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__________________________________________ DATE OF BIRTH________
STUDENT ID # _______________ SFSU 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:

Registrar's Office, SSB 303
San Francisco State University
1600 Holloway Avenue
San Francisco, CA  94132

Registrar, One Stop
Student Service Center, SSB
Phone:  415-338-2350 (Mon - Fri 9-12 and 1-4)
FAX:  415-338-0588
http://health.sfsu.edu/content/vaccinations-and-immunizations

ALL STUDENTS* BORN ON OR AFTER January 1, 1957

Measles, Mumps, Rubella (MMR) Vaccine
Date of dose #1 _______________
Date of dose #2 _______________
OR
Results of a blood test indicating immunity
Date of blood test_________________
Results_________________________

If you were born before 1957, check with your academic department to see if immunizations are needed for curriculum requirements e.g., 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.

Hepatitis B Vaccine
Date of dose #1_________________
Date of dose #2_________________
Date of dose #3_________________
OR
Results of a blood test indicating immunity.
Date of blood test_________________
Test performed_________________
Results_________________________

Also NEED Proof of MMR Vaccination – See Previous Column

CERTIFICATION BY MD / NP / PA / RN

Name_____________________________________________________
Address_____________________________________________________
Date____________________  License #________

CERTIFICATION BY MD / NP / PA / RN

Name_____________________________________________________
Address_____________________________________________________
Date____________________  License #________

REGISTRAR'S OFFICE ACCEPTS MAILED COPIES – DO NOT EMAIL - DO NOT SUBMIT ORIGINALS