

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:	Questions?
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	STUDENTS 18 YEARS OR YOUNGER
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 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.	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	CERTIFICATION BY MD / NP / PA / RN
Name _____ Address _____ Date _____ License # _____	Name _____ Address _____ Date _____ License # _____

Office Stamp

Office Stamp

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