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 Name_____ Address_____ Date_____ License #_____ Office Stamp	**CERTIFICATION BY MD / NP / PA / RN** Name_____ Address_____ Date_____ License #_____ Office Stamp

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