

## UNDERGRAD Proof of Immunization Record

In compliance to **State of Tennessee Department of Health regulations**, <u>ALL</u> students must complete Sections A and B; all full-time students and students living on campus must also complete Section C. **Failure to provide proof of immunization will result in not being allowed to attend classes. New undergraduates will not be assigned housing until the completed form is received.** 

| Section A: Student Informati                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | n and Health Ir                                                   | surance                                                                                                                                            |  |  |  |  |  |  |
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| Full Name:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                   | Birthdate:                                                                                                                                         |  |  |  |  |  |  |
| Address:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                   |                                                                                                                                                    |  |  |  |  |  |  |
| City/State/Zip:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                   |                                                                                                                                                    |  |  |  |  |  |  |
| Email:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                   |                                                                                                                                                    |  |  |  |  |  |  |
| Primary Phone Contact:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | □ Cell                                                            | □ Cell □ Home □ Other                                                                                                                              |  |  |  |  |  |  |
| Secondary Phone Contact:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | □ Cell                                                            | <br>□ Cell □ Home □ Other                                                                                                                          |  |  |  |  |  |  |
| Month and Year of Entry:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ☐ Full-1                                                          | - 3                                                                                                                                                |  |  |  |  |  |  |
| Health Insurance Company:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                   |                                                                                                                                                    |  |  |  |  |  |  |
| Policy Holder Name:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                   | Policy #:                                                                                                                                          |  |  |  |  |  |  |
| Section B: Required and Rec                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | mmended Vaco                                                      | inations                                                                                                                                           |  |  |  |  |  |  |
| Required Full-time students and any student living on campus                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                   | Recommended                                                                                                                                        |  |  |  |  |  |  |
| MMR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                   | Hepatitis B                                                                                                                                        |  |  |  |  |  |  |
| Varicella  Meningococcal (if under age 22 and living on campus)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                   | Polio<br>DPT, DTaP, DT, Tdap                                                                                                                       |  |  |  |  |  |  |
| Wiching ococcar (ii dirider age 22 <u>and</u> living on campus)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Men                                                               | ingococcal (if living on campus)                                                                                                                   |  |  |  |  |  |  |
| diseases. The information concerning these diseases is from the Centers for Disease control (CDC) and the American College Health Association. For more information about these diseases and vaccines, please contact your local healthcare provider or visit the CDC website at <a href="https://www.cdc.gov/health/default.htm">www.cdc.gov/health/default.htm</a> . ALL STUDENTS are required to respond to the statements below and sign at the bottom. Hepatitis B (HBV) is a serious viral infection of the liver that can lead to chronic liver disease, cirrhosis, liver cancer, liver failure, and even death. The disease is transmitted by blood and/or body fluids, and many people will have no symptoms when they develop the disease. The primary risk factors for hepatitis B are sexual activity and injection drug use. This disease is completely preventable with the Hepatitis B vaccine which is available to all age groups. A series of three (3) doses of vaccine are required for optimal protection. Missed doses may still be sought to complete the series if only one or two doses have been acquired. The HBV vaccine has a record of safety and is believed to confer lifelong immunity in most cases.  I hereby certify that I have read this information about Hepatitis B (HBV) and have elected not to receive the Hepatitis B vaccine.  Meningococcal Disease is a rare but potentially fatal bacterial infection, expressed as either meningitis (infection of the membranes surrounding the brain and spinal cord) or meningococcemia (bacteria in the blood). Meningococcal disease strikes about 3,000 Americans each year and is responsible for about 300 deaths annually. The disease is spread by airborne transmission primarily by coughing. The disease can onset very quickly and without warning. Rapid intervention and treatment is required to avoid serious illness and/or death. There are five different subtypes (serogroups) of the bacterium that cause Meningococcal Meningitis. The current vaccine does not stimulate protective antibodies to Serogroups B, but |                                                                   |                                                                                                                                                    |  |  |  |  |  |  |
| days. The Advisory Committee on Immunization Practices (ACIP) of the Center freshman (particularly those who live in dormitories or residence halls) be inforthat those students who wish to reduce their risk for disease to be immunized may choose to be vaccinated.  I hereby certify that I have read this information and have elected not                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | s for Disease Contro<br>ned about meningoo<br>any undergraduate s | I and Prevention (CDC) recommends that college occal disease and the benefits of vaccination and tudents who wish to reduce their risk for disease |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                   | •                                                                                                                                                  |  |  |  |  |  |  |
| I hereby certify that I have read this information and have received the                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                   |                                                                                                                                                    |  |  |  |  |  |  |
| Student signature:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                   |                                                                                                                                                    |  |  |  |  |  |  |
| Parent/Guardian signature if student under age 18:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                   | Date <sup>.</sup>                                                                                                                                  |  |  |  |  |  |  |



## UNDERGRAD Proof of Immunization Record

|                    | UNIVERSITY                                                                                                                                                                            |                                              |                                     |                                      |                                           |                         | · • · · · · · · · · · · · · · · · · · · |                               | on Record            |
|--------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|-------------------------------------|--------------------------------------|-------------------------------------------|-------------------------|-----------------------------------------|-------------------------------|----------------------|
| tude               | nt Signature:                                                                                                                                                                         |                                              |                                     |                                      |                                           |                         | Birthdat                                | e:                            |                      |
|                    |                                                                                                                                                                                       | Section                                      | C: Proof o                          | f Immuniza                           | ation                                     |                         |                                         |                               |                      |
|                    | NOTICE: To be completed and signed                                                                                                                                                    | d by the <b>Hea</b>                          | Ithcare Prov                        | i <b>der</b> or attach               | n an officia                              | I copy of               | your imr                                | nunization                    | records.             |
|                    |                                                                                                                                                                                       |                                              |                                     |                                      | In lieu of vaccination                    |                         |                                         |                               |                      |
|                    | Vaccine                                                                                                                                                                               | <b>Date</b> (mm/dd/yy)                       | Date<br>(mm/dd/yy)                  | <b>Date</b> (mm/dd/yy)               | Total<br>Doses                            | Serol<br>Posit<br>(mm/d | ive                                     | Disease<br>History<br>(mm/yy) | Medical<br>Exemption |
|                    | MMR<br>(Born after 1956, 2 doses OR +<br>serology)                                                                                                                                    |                                              |                                     |                                      |                                           | ,                       |                                         |                               |                      |
|                    | Measles                                                                                                                                                                               |                                              |                                     |                                      |                                           |                         |                                         |                               |                      |
| <u> </u>           | Mumps                                                                                                                                                                                 |                                              |                                     |                                      |                                           |                         |                                         |                               |                      |
| 3                  | Rubella                                                                                                                                                                               |                                              |                                     |                                      |                                           |                         |                                         |                               |                      |
| Required           | Varicella (Born after 1979, 2 doses OR + serology OR credible history of chicken pox)                                                                                                 |                                              |                                     |                                      |                                           |                         |                                         |                               |                      |
|                    | Meningococcal (MCV4)<br>(1 Dose on or after 16 <sup>th</sup> birthday if under<br>age 22)                                                                                             |                                              |                                     |                                      |                                           |                         |                                         |                               |                      |
| Kecommended        | Hepatitis B (3 doses: Required for students in health science prior to patient care.)                                                                                                 |                                              |                                     |                                      |                                           |                         |                                         |                               |                      |
| me<br>m            | Polio                                                                                                                                                                                 |                                              |                                     |                                      |                                           |                         |                                         |                               |                      |
| E 0                | (Primary series)                                                                                                                                                                      |                                              |                                     |                                      |                                           |                         |                                         |                               |                      |
| ב<br>ב             | Tetanus DPT, DTap, DT, Tdap (TD booster within 10 years)                                                                                                                              |                                              |                                     |                                      |                                           |                         |                                         |                               |                      |
| hist<br>cree<br>PD | placement, IGRA testing, x-ray, and ap<br>tory of disease or BCG vaccination sho<br>ening Assessment (REQUIRED):<br>Test: Date Given://<br>st X-ray (required for positive test): □ P | uld not preclu<br>□ Low Risk<br>Date Test Re | ude testing of<br>□ High<br>ead:/   | a member o<br>Risk (addition<br>_/ F | f a high ris<br>nal testing re<br>Result: | k group.<br>equired)    | _mm.                                    | □ Positive                    | □ Negativ            |
| lea                | althcare Provider Name:                                                                                                                                                               |                                              |                                     |                                      |                                           |                         | Phone:                                  |                               |                      |
| ∖dd                | lress:                                                                                                                                                                                |                                              |                                     |                                      | City/Stat                                 | te/Zip:                 |                                         |                               |                      |
| lea                | Ilthcare Provider Signature:                                                                                                                                                          |                                              |                                     |                                      | ,                                         | '                       | Date:                                   |                               |                      |
|                    |                                                                                                                                                                                       | Section                                      | D: Religio                          | ous Exemp                            | tion                                      |                         |                                         |                               |                      |
|                    | NOTICE: Must be notarize                                                                                                                                                              |                                              | •                                   | -                                    |                                           | ious bali               | ofe and r                               | ractices                      |                      |
| unc                | derstand that under Tennessee Law and/or N                                                                                                                                            | •                                            | •                                   |                                      | ·                                         |                         | •                                       |                               | accinated            |
| gai                | nst the below stated diseases or to obtain a                                                                                                                                          | medical or reli                              | gious waiver fro                    | om this law an                       | d/or policy.                              | I have re               | viewed the                              | e CDC webs                    | ite informatior      |
| nm                 | rding the indicated immunizations at: <a href="http://vunizations">http://vunizations</a> include: becoming infected with the quarantine during an outbreak.                          | he disease, de                               | accines/pubs/v<br>eath, transmittir | ng vaccine-pre                       | and underst<br>ventable dis               | ease to o               | thers, exc                              | sks of not re-<br>lusion from | ceiving<br>school or |
| he                 | following indicated immunization(s) is (                                                                                                                                              | are) prohibito<br>□ Rubella                  | ed by my reliç<br>□ Vario           |                                      | and praction                              |                         | □H                                      | epatitis B s                  | series               |
|                    | Student Signature                                                                                                                                                                     | D                                            | oate                                | If un                                | der 18, Pare                              | ent/Guard               | ian Signat                              | ture                          | Date                 |
| ОТ                 | TARY PUBLIC:                                                                                                                                                                          |                                              |                                     | NOTARY S                             | EAL:                                      |                         |                                         |                               |                      |
|                    |                                                                                                                                                                                       |                                              |                                     |                                      |                                           |                         |                                         |                               |                      |

Sworn and subscribed before this

, 20\_

day of \_