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# MANDATORY STUDENT IMMUNIZATION REQUIREMENTS 2 of 2

Student Name ________________________________________________________________________ Student ID __________________________________________

According to the Tennessee Department of Health, new full-time students are required to provide proper immunization for measles, mumps, and rubella (MMR) as well as Varicella (Chickenpox). For each group, check the statements that describe how you have met the requirements.

**Group one: Select one response about the MMR vaccines:**

____ I was born before January 1, 1957. (The vaccines are not required.)

____ I graduated from high school after May 1, 1999. (The vaccines are not required.)

____ I graduated from high school between May 1979 and December 1998. I am not required to have the first dose, but I am providing documentation from a licensed healthcare provider that I have had the 2nd dose. (Must attach documentation of the second dose.)

____ I am providing documentation from a licensed healthcare provider that I have received two doses of the MMR vaccine. (Must attach documentation of the two doses of the MMR vaccine.)

____ I have been previously diagnosed with Measles, Mumps, and Rubella. Healthcare provider to initial here and sign below: ____________ (The vaccines are not required.)

____ I am medically exempted because of risk of harm. List reason(s) __________________________________________ Healthcare provider to initial here and sign below: _____________ (The vaccines are not required.)

____ I am a transfer student and have previously been enrolled as a full-time student at a college or university. My first semester at the institution was after August 1, 2007. List institution: __________________________________ (The vaccines are not required.)

____ Measles, Mumps, and Rubella antibodies were tested on the below date(s) with the following results. I understand that I must show immunity in all three areas for the vaccines to be required. Healthcare provider to initial here and sign below: _________

**Measles** Date: ______________ Immunity: Y N **Mumps** Date: ______________ Immunity: Y N **Rubella** Date: ______________ Immunity: Y N

**Group two: Select one response about the Chickenpox (Varicella) vaccine:**

____ I was born before January 1, 1980. (The vaccines are not required.)

____ I graduated from high school in May 2016 or later. (The vaccines are not required.)

____ I graduated from high school between 1999 and May 2016. I am not required to have the first dose but am providing documentation from a licensed healthcare provider that I have had the second dose. (Must attach documentation of second dose of the Varicella vaccine.)

____ I am providing documentation from a licensed healthcare provider that I have received two doses of the Varicella vaccine. (Must attach documentation of two doses of the Varicella vaccine.)

____ I have been previously diagnosed with Chickenpox disease. Healthcare provider to initial here and sign below: __________ (The vaccines are not required.)

____ I am medically exempted because of risk of harm. List reason(s) __________________________________________ Healthcare provider initials _____________ (The vaccines are not required.)

____ I am a transfer student & have previously been enrolled as a full-time student at a college or university. My first semester at the institution was after August 1, 2011. List institution: __________________________________ (The vaccines are not required.)

____ Varicella antibody was tested on the below date with the following results. I understand that I show immunity for the vaccine to not be required. Healthcare provider to initial here and sign below: _____________

____ Other valid exemption: I am attaching a signed written statement, affirmed under the penalty of perjury, which states that my religious tenets and practices prevent me from being vaccinated. I understand that I may not be admitted to a program where I have contact with medical patients without required immunizations. (Must attach signed written statement. The vaccines are not required.)

__________________________________________________________________________________ __________________________________________

Student Signature Date

__________________________________________________________________________________ __________________________________________

Healthcare Provider's Signature Date