TENNESSEE STATE UNIVERSITY

T# ____________________

CERTIFICATE OF IMMUNIZATION

Name: ____________________ **Birth Date:** ____________________

Immunizations refused because of religious objections.
Student check here, signs and dates the form, and attaches a notarized statement

Part I (REQUIRED FOR REGISTRATION): Measles, mumps, and rubella immunization.
Must meet one of the following criteria:

Born before 1957, therefore, is exempted from requirement.

Health Care Provider must complete the sections below.
Medically contraindicated because of pregnancy, allergy to the vaccine. etc
List reason(s) ____

Received two doses of MMR vaccine, at least 28 days apart.
Dose 1 of MMR vaccine (month/day/year) ___/___/___
Dose 2 of MMR vaccine (month/day/year) ___/___/___
Blood serology test (titer test) for measles, mumps, rubella showing immunity.
Dates of test (month/day/year) ___/___/___ **(Please submit printed copy of titer results)**

PART II (REQUIRED FOR REGISTRATION): Varicella (chicken pox) immunization: Must meet one of the following criteria:

Born before 1980, therefore, is exempt from requirement.

Health Care Provider must complete the section below.
Medically contraindicated because of pregnancy, allergy to the vaccine, etc
List reason(s) ___________________________________

History of varicella (chicken pox) verified by a health care provider.
Date of the disease (month/year) ___/____

Received two doses of varicella (chicken pox) vaccine, at least 28 days apart.
Dose 1 of varicella vaccine (month/day/year) ____/____/____
Dose 2 of varicella vaccine (month/day/year) ____/____/____
Blood serology test (titer) showing immunity to varicella (chicken pox).
Date of test (month/day/year) ___/___/____ **(Please submit printed copy of titer results)**

PART III Tetanus-diphtheria. Complete the section that applies.
Complete primary series of tetanus-diphtheria immunization (month/year) ___/____
Tetanus-diphtheria booster within last ten years ___/___/___

PART IV Meningococcal Meningitis. Complete the sections that applies
The state required that on July 1, 2013, that the Meningococcal Meningitis vaccine will be required if student is staying in student housing.
Medically contraindicated because of pregnancy, allergy to the vaccine. etc
List reason(s) ____
Dose 1 of meningitis vaccine (month/day/year) ____/____/____
Dose 2 of meningitis vaccine (month/day/year) ____/____/____

Health Care Provider:
Name: _______________________________________
Signature or stamp _____________________________
Address ____________________ **Phone** __________________
City, State __________________ **Date** ___________________
Signature of Student ____

(YOU WILL NOT BE PERMITTED TO REGISTER UNTIL YOU COMPLETE AND RETURN THIS FORM. THIS FORM MUST BE SIGNED AND STAMPED BY YOU PHYSICAN OR HEALTH DEPT. PROVIDING THE DOCUMENTATION)

Return forms to: **Tennessee State University**
Student Health Services
3500 John A. Merritt boulevard
Nashville, TN 37209
Phone: 615-963-5291
Fax: 615-963-5084

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