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 Phone: 615-963-5291

 Student Health Services Fax: 615-963-5084

 3500 John A. Merritt boulevard Nashville, TN 37209

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