



STATE OF TENNESSEE
DEPARTMENT OF HEALTH

**Immunization Documentation for New Full-Time Students in a
Tennessee Higher Education Institution**

This may be used to provide a record that a new student has met the requirement of the Tennessee Department of Health (Rules Chapter 1200-14-1-.29) for immunity to measles, mumps, rubella and/or varicella (chickenpox), when a specific institution's form is not available. This must be signed by a qualified healthcare provider (physician, advanced practice nurse, physician assistant, or public health nurse of a Tennessee public health department). Distance learning (e.g., online) and part-time students are exempt from state requirements. *This does not address hepatitis B vaccination required by the state for students involved in patient care as part of training for a healthcare profession.*

Students may be subject to additional institutional immunization requirements. Students should address questions about institutional requirements or religious exemption policies to the institution.

Student Name: _____ **Date of birth** (___/___/___)

Measles, Mumps, Rubella (Check one. If indicating vaccination or serology, dates required.)

- Born before 1957, therefore presumed immune through past illness *or*
- 2 doses of measles, mumps, rubella vaccines (no earlier than 4 days before 1st birthday, ≥28 days apart)
Dates: ___/___/___ and ___/___/___, *or*
- Serology (IgG) positive for measles *and* mumps *and* rubella: Year _____, *or*
- Medical exemption (vaccination is contraindicated because of an excess risk of harm)
- Incomplete.** One dose of vaccine given ___/___/___, next dose due after ___/___/___
- Status not assessed at this visit (check if student only needs varicella documentation on this form)

Varicella or "chickenpox" (Check one. If indicating vaccination or serology, dates required.)

- Born before 1980, therefore presumed immune through past illness *or*
- The healthcare provider named below believes the student has had chickenpox:
Year of illness (optional): _____, *or*
- 2 doses of varicella vaccine (given no earlier than 4 days before 1st birthday, ≥28 days apart)
Dates: ___/___/___ and ___/___/___, *or*
- Serology (IgG) positive for varicella: Year _____, *or*
- Medical exemption (vaccination is contraindicated because of an excess risk of harm)
- Incomplete.** One dose of vaccine given ___/___/___, next dose due after ___/___/___
- Status not assessed at this visit (check if student only needs MMR documentation on this form)

Healthcare provider (printed or stamped name & address, and signature)

Date: ___/___/___