

**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:**

Signature or stamp \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

City, State \_\_\_\_\_

Date \_\_\_\_\_

Signature of Student \_\_\_\_\_

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

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