

# CERTIFICATE OF IMMUNIZATION

In compliance with Tennessee State Law, all Board of Regents institutions are requiring proof of two immunizations with the Measles, Mumps, and Rubella (MMR) vaccine and (effective July 2011) two immunizations with Varicella (chickenpox) vaccine.

NEW INCOMING STUDENTS RESIDING IN ON-CAMPUS HOUSING, WHO ARE LESS THAN 22 YEARS OF AGE, MUST HAVE DOCUMENTATION OF HAVING RECEIVED A MENINGOCOCCAL VACCINE WITHIN THE PAST 5 YEARS TO LIVE ON CAMPUS.

**Please upload this completed form to the APSU online portal:  
peayhealth.apsu.edu, fax to: 931-221-7388, or email to: lucasd@apsu.edu.**

For additional questions, call 931-221-7107.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ Student I.D A# \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ Zip Code \_\_\_\_\_ Phone \_\_\_\_\_

## Part 1-MMR

If you graduated from a Tennessee high school after 1998, you are not required to fill out Part 1 of this form.  
If you were born before 1957, you are not required to fill out Part 1 of this form.

1. Date of MMR #1. \_\_\_\_\_ (MM / DD / YYYY)  
Date of MMR #2. \_\_\_\_\_ (MM / DD / YYYY)
2. **OR** Clinical diagnoses of:  
Measles: Year: \_\_\_\_\_  
Mumps: Year: \_\_\_\_\_  
Rubella: Year: \_\_\_\_\_
3. **OR** Laboratory proof of immunity:  
Measles: Year: \_\_\_\_\_ Titer results: \_\_\_\_\_  
Mumps: Year: \_\_\_\_\_ Titer results: \_\_\_\_\_  
Rubella: Year: \_\_\_\_\_ Titer results: \_\_\_\_\_
4. **OR** medically contraindicated (allergy, pregnancy, other). **Please attach provider's statement regarding medical condition.**
5. **OR** I affirm under penalty of perjury that I have not and/or will not obtain(ed) vaccinations because it conflicts with my religious practices. **FORM MUST BE NOTARIZED OR HAVE AN ATTACHED NOTARIZED LETTER.**

## Part 2-VARICELLA (Effective July 1, 2011)

If you were born before Jan. 1, 1980, you are not required to fill out Part 2 of this form. If you graduated from a TN high school in 2016 or after you are not required to fill out Part 2 of this form.

1. Date of Varicella #1. \_\_\_\_\_ (MM / DD / YYYY)  
Date of Varicella #2. \_\_\_\_\_ (MM / DD / YYYY)

- 2. **OR** Clinical diagnoses of Varicella           Year: \_\_\_\_\_
- 3. **OR** Laboratory proof of immunity for Varicella           Year: \_\_\_\_\_    Titer results: \_\_\_\_\_
- 4. **OR** medically contraindicated (allergy, pregnancy, other). **Please attach provider's statement regarding medical condition.**
- 5. **OR** I affirm under penalty of perjury that I have not and/or will not obtain(ed) vaccinations because it conflicts with my Religious practices. **FORM MUST BE NOTARIZED OR HAVE AN ATTACHED NOTARIZED LETTER.**

**Part 3- MENINGOCOCCAL (effective July 1, 2013) ON CAMPUS HOUSING STUDENTS ONLY**

If you are less than 22 years of age and residing in on-campus housing, a single dose of MCV4 must have been administered within the past 5 years.

- 1. Date of Meningitis. \_\_\_\_\_ (within the last 5 years to be current).  
(MM / DD / YYYY)
- 2. **OR** medically contraindicated (allergy, pregnancy, other). **Please attach provider's statement regarding medical condition.**
- 3. **OR** I affirm under penalty of perjury that I have not and/or will not obtain(ed) vaccinations because it conflicts with my religious practices. **FORM MUST BE NOTARIZED OR HAVE AN ATTACHED NOTARIZED LETTER.**

**STUDENTS UNDER THE AGE OF 18 AT THE TIME OF REGISTRATION:**

IF STUDENT IS UNDER THE AGE OF 18 AT TIME OF CLASS REGISTRATION, THE HEP/MEN HEALTH HISTORY FORM MUST BE SIGNED BY A PARENT AND TURNED IN TO HEALTH SERVICES. IF LIVING ON CAMPUS, THE HEP/MEN FORM MUST ACCOMPANY PROOF OF MENINGITIS VACCINATION WITHIN THE LAST 5 YEARS.

**INTERNATIONAL STUDENTS:**

INTERNATIONAL STUDENTS MUST COMPLY WITH ALL IMMUNIZATION POLICIES PRIOR TO REGISTERING FOR CLASSES BUT MUST ALSO TURN IN PROOF OF FREEDOM OF TB BY LETTER FROM PHYSICIAN, OR NEGATIVE TB TESTING OR CHEST X-RAY WITHIN 30 DAYS OF 1<sup>ST</sup> DAY OF CLASS.

TB TEST:                   Date: \_\_\_\_\_ Results: \_\_\_\_\_

**OR** CHEST XRAY:           Date: \_\_\_\_\_ Results: \_\_\_\_\_

**OR** ATTACHED LETTER FROM PHYSICIAN STATING TB FREE

**THIS FORM MUST BE COMPLETED AND SIGNED/STAMPED BY A MEDICAL PROVIDER OR OFFICE.**

Health Care Provider:   Provider Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

STUDENT NAME: \_\_\_\_\_ A#: \_\_\_\_\_