University Health Center

Southern Adventist University
PO Box 370, Collegedale, TN 37315 Phone: 423.236.2713 Fax: 423.236.1713

Immunization Form

Name: _____ **SAU ID #:** _____

In order for you to register for classes a health care provider must complete this form along with their signature or office stamp in the appropriate space. Please attach an updated copy, **in English**, of your immunizations.

Immunization Requirements

1. **MMR:** All students born on or after January 1, 1957, must provide proof of immunization with two doses of MMR vaccine at least 28 days apart (OR) serology showing immunity to MMR.
2. **Varicella or Chickenpox:** All students born on or after January 1, 1980, must provide proof of immunization with two doses of Varicella vaccine at least 28 days apart, (OR) serology showing immunity to Varicella, (OR) documentation from a medical facility verifying a previous diagnosis with the illness.
3. **TB:** All incoming students taking classes on campus must submit either a PPD or an IGRA (Quantiferon Gold or Tspot) result dated within the last 6 months (OR) chest Xray results and/or treatment completion certificate, as appropriate.
4. **Hepatitis B:** All students must either provide proof of immunization with three doses of Hepatitis B vaccine (OR) documentation of serology showing immunity to Hepatitis B virus, (OR) having read the provided Hepatitis B information sheet, initial below indicating the desire to waive the vaccine, understanding said risks/benefits.
5. **Meningitis:** All students must either provide proof of immunization to Meningitis/MCV4 at 16 years of age or older (OR) having read the provided Meningitis information sheet, initial below indicating the desire to waive the vaccine, understanding said risks/benefits. If student initially had vaccine prior to age 16, they will need a booster dose.

Vaccine	Dates	Provider's Signature or Office Stamp
MMR (Measles, Mumps, Rubella) □ Born before 1957	Dose #1: _____ #2 _____ Titer: _____	
Varicella (Chickenpox) □ Born before 1980	Date of Disease _____ Dose #1: _____ #2 _____ Titer: _____	
TB (Tuberculosis)	Date: _____/_____ mm IGRA: _____ □ CXR Attached	
Hepatitis B Series of 3 □ I choose to waive _____ Initial/date	Dose #1: _____ #2 _____ Dose #3: _____ Titer: _____	
Meningococcal/MCV4 □ I choose to waive _____ Initial/date	Dose after age 16: _____	

□ I have attached a physician's statement documenting **medical contraindication or immunity**.

□ **I Claim Religious Exemption.** The form at www.southern.edu/universityhealth **must** be attached if claiming exemption.

I certify these immunization records are accurate.

Health Care Provider Signature: _____ Date: _____

Print Name: _____ Phone Number: _____