LEE UNIVERSITY

CERTIFICATE OF IMMUNIZATION

(Questions regarding this form should be directed to Health Services at 423-614-8430.)

Name ____ (Please print)

Social Security # ____

Date of Birth ____

THE STATE OF TENNESSEE AS OF JULY 1, 1998 REQUIRES STUDENTS ENTERING COLLEGES, UNIVERSITIES, AND TECHNICAL INSTITUTES TO HAVE WRITTEN PROOF FROM A HEALTHCARE PROFESSIONAL OF TWO DOSES OF MEASLES, MUMPS, AND RUBELLA VACCINE PRIOR TO REGISTRATION.

AS OF JULY 1, 2011, THE STATE OF TENNESSEE WILL REQUIRE EITHER WRITTEN PROOF OF HAVING HAD CHICKEN POX OR, THE DOCUMENTATION OF AT LEAST THE FIRST DOSE OF THE CHICKEN POX VACCINE (VARICELLA) PRIOR TO REGISTRATION.

IN ADDITION, LEE UNIVERSITY REQUIRES THAT ALL INTERNATIONAL STUDENTS HAVE PROOF OF A TB (TUBERCULOSIS) SKIN TEST THAT WAS ADMINISTERED WITHIN THE PAST 12 MONTHS.

This **Certificate of Immunization** form **must** be completed and signed by a **Licensed Health Care Provider**, and returned to Lee University **prior to registration**,

OR

You may submit an official copy of a State Health Department or Military Record of Immunization form instead.

PART I
(IF APPLICABLE)

_____ Refused immunization(s) because of religious beliefs or medical reasons. Appropriate forms can be downloaded at www.leeuniversity.edu/health-services/forms.aspx.

Attaching a statement of attestation and scheduling a conference with the Health Clinic Director is required.

____
Name

PART II
(MUST BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER OR ATTACH AN OFFICIAL COPY OF YOUR IMMUNIZATION RECORD)

MMR (Check appropriate statement)

☐ Received two (2) doses of MMR vaccine since the age of twelve months:

Mo/Day/Yr ____________ Mo/Day/Yr ____________

If vaccine is medically contraindicated, list the reason(s) below:

____

____

☐ Had disease(s) confirmed by medical record Mo/Yr ____________

☐ Laboratory confirmed immunity to the disease by titer ____________

Print name of **Physician** OR **Health Professional** ____________

Office Telephone ____________

Address ____________

City ____________ State ____________ Zip ____________

Health Professional Signature ____________ **Date** ____________

PART III
CHICKEN POX IMMUNIZATION(S)

☐ Official Immunization Record attached verifying Chicken Pox disease

☐ Official Immunization Record attached with dates of Varicella Vaccine given:

First dose date ____________Mo/Yr. Second dose date ____________Mo/Yr.

PART IV
MUST BE COMPLETED BY A LICENSED HEALTH CARE PROVIDER OR ATTACH AN OFFICIAL COPY OF IMMUNIZATION RECORD

TUBERCULIN (PPD) SKIN TEST FOR INTERNATIONAL STUDENTS

Date of Tuberculin skin test (PPD) received within the past 12 months ____________

Positive Reading ____________ mm Negative Reading ____________

Print name of **Physician** OR **Health Professional** ____________

Address ____________

City ____________ Country ____________

Health Provider Signature ____________ **Date** ____________