**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 MMR 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: ____/____/____ |

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