



IMMUNIZATION RECORD

HEALTH SERVICES

Parts A-C are required for all students. Part D is required for all residents.

Name _____ Date of Birth _____ Phone # _____

Address _____ Email _____

A. MEASLES, MUMPS, AND RUBELLA (check one):

Attach copy of Immunization record showing two (2) doses of Measels, Mumps & Rubella (MMR) vaccine

Attach copy of immune MMR titer Date: ___/___/___ Results _____

The state of Tennessee requires all students, born after January 1, 1957, entering colleges and universities to provide proof of two (2) doses of Measles, Mumps, and Rubella (MMR) vaccine on or after the first birthday or proof of immunity to measles with an MMR titer (blood test).

B. VARICELLA OR "CHICKENPOX" (check one):

Attach copy of Immunization record showing two (2) doses of varicella vaccine

Attach copy of immune varicella titer Date: ___/___/___ Results _____

Attach letter from health care provider stating that he/she believes student has had chickenpox. Year of illness: _____

The state of Tennessee requires all students born on or after January 1, 1980 to provide proof of two doses of varicella (chickenpox) vaccine given no earlier than 4 days before 1st birthday or proof of immunity to varicella with a varicella IgG (titer) blood test.

C. HEPATITIS B (HBV) IMMUNIZATION:

Recommended for all new students and required for students in the School of Nursing. Hepatitis B (HBV) is a serious viral infection of the liver that can lead to chronic liver disease, cirrhosis, liver cancer, liver failure, and even death. Hepatitis B vaccine is available to all age groups to prevent Hepatitis B viral infection. A series of three (3) doses of vaccine are required for optimal protection. Missed doses may still be sought to complete the series if only one or two have been acquired. The HBV vaccine has a record of safety and is believed to provide lifelong immunity in most cases. Union University Health Services, located on the Jackson Campus, is open Monday - Friday 8 a.m.-4p.m. and offers Hepatitis B vaccine for \$50 per injection (price subject to change).

I decline receipt of vaccine to protect for Hepatitis B.

I have received the complete three dose series of the Hepatitis B vaccine.

I plan to receive the Hepatitis B series.

Student Must Sign Here _____ Date _____

D. MENINGITIS VACCINE:

Recommended for all students living in campus housing _____ Living Off Campus

College students, especially freshman living in residence halls, are at an increased risk for contracting meningococcal disease. The bacterial form of this disease can lead to serious complications such as swelling of the brain, coma, and even death within a short period of time. Immunization can prevent up to 80% of meningococcal meningitis in young adults. The vaccine is safe and effective against 4 of the 5 types of bacteria responsible for meningococcal meningitis in the United States and for the majority of the cases in the college age population. Protection lasts approximately 8 years. Union University Health Services is open Monday -Friday, 8 a.m.-4 p.m. and offers the meningitis vaccine for \$100 (price subject to change).

I decline receipt of vaccine for meningococcal meningitis.

I have received or plan to receive the meningococcal meningitis vaccine. Meningitis Vaccine (Date Given) ___/___/___

I plan to receive the meningococcal meningitis vaccine.

Student Must Sign Here _____ Date _____

I refuse immunization because of religious objections, have attached an official clergy statement, and affirm this reason under the penalties of perjury.

Signature _____ Date _____

To be completed by new students.

Full Name _____
First Middle Last

Gender M F Age _____ Birthdate _____ SSN _____
(optional)

Home Address _____
Street City State Zip

Phone () _____ Expected Date of Enrollment _____

Name of Parent, Guardian or Spouse (circle one) _____

Phone () _____ Home Address _____
Street City State Zip



***Attach a copy of both sides of insurance ID card**

Current Medication(s): _____

Current Health Problems and Past Health Problems including serious injuries, medical conditions and surgeries: _____

Allergies (Medications, Foods, Substances, etc.) _____

Student Treatment Consent

In case of serious illness or accident, I give Union University or its representative(s) permission to secure medical and/or surgical care to include transportation to a doctor or hospital of their choice, injections, examination, medication, and surgery that is considered necessary for my good health. I agree to pay all medical costs. In the event of a condition requiring minor care, I give my permission for treatment to the college physician or his staff.

All statements in this medical record are true to the best of my knowledge and belief. Should any change in my health status occur I understand that Student Health Services should be notified in writing.

 Student's Signature Date Parent/Guardian's Signature (if student is under 18) Date

Consent for Release of Information

In order to provide continued and appropriate medical care, I give Union University or its representative(s) permission to release personal health information to health care professionals/medical facilities by E-mail, FAX, phone and mail.

 Student's Signature Date