

SCHOOL OF LETTERS

PLEASE SUBMIT IMMUNIZATIONS ON THIS FORM. All students in the School of Letters are required to provide proof of immunization prior to enrollment in classes. If you have any questions, please direct them to University Health Service: (931) 598-1777. **Records must be submitted no later than June 4th**. Please fax this completed form to (931) 598-1746 or email to healthservice@sewanee.edu. Hardcopies may be mailed to University Health Service, University Wellness Center, SPO 1182, Sewanee, TN 37383-1000.

Student's Name: _____ Date of Birth: _____ Last 4 of SSN: _____

Tuberculosis (TB) Skin Test – (Must be within the past 6 months) (N/A or Uncompleted is Not Acceptable)

1. Date placed / / Read / / Result (in millimeters) mm Positive Negative
M D YR M D YR

2. If PPD is positive, chest x-ray or Quantiferon testing is required.

X-ray Date: _____ Result: ___ normal ___ abnormal

Quantiferon Test Date: _____ Result: ___ negative ___ positive

****IF QUANTIFERON GOLD TEST OR CHEST X-RAY IS POSITIVE, ADDITIONAL TREATMENT PLAN MUST BE ATTACHED/SUBMITTED****

MMR (measles, mumps, rubella) – two doses are required or proof of immunity.

1. Dose 1 (at age 12 mos. or later) / /
M D YR

2. Dose 2 (at least 28 days after 1st dose) / /
M D YR

3. Mumps Antibody Titer: / / Result: ___ (Reactive/Immunity) ___ (Non-Reactive)
M D YR

Rubella Antibody Titer: / / Result: ___ (Reactive/Immunity) ___ (Non-Reactive)
M D YR

Rubeolla Antibody Titer: / / Result: ___ (Reactive/Immunity) ___ (Non-Reactive)
M D YR

Tetanus, diphtheria, pertussis – tetanus/diphtheria/pertussis (Tdap) is required within the last 10 years. Tetanus/diphtheria (Td) is not sufficient. Tdap booster recommended for ages 11 – 64 unless contraindicated. If Tdap will expire in the next 3 years please boost.

1. Tdap / /
M D YR

Hepatitis B – three doses of Hepatitis B are required.

1. Dose (1) / / (2) / / (3) / /
M D YR M D YR M D YR

2. Hepatitis B Surface Antibody Titer / / Result: ___ (Reactive/Immunity) ___ (Non-Reactive)
M D YR

Varicella – history of chicken pox disease, two doses of the vaccine or a positive antibody titer is required to meet the requirements.

1. Date of disease: / /
M D YR

2. Varicella Immunizations: (1) / / (2) / /
M D YR M D YR

3. Varicella Antibody Titer: / / Result: ___ (Reactive/Immunity) ___ (Non-Reactive)
M D YR

*****STUDENTS AGE 22 AND UNDER ARE ALSO REQUIRED TO HAVE PROOF OF ONE MENINGOCOCCAL VACCINE AFTER AGE 16*****

Meningococcal (A, C, Y, W-135) – One dose required after the sixteenth birthday.

1. Menactra/Menveo / / **(MUST BE AFTER AGE 16)**
M D YR

Any Titers that report as Non-Reactive will require Patient to receive vaccinations, unless contraindicated.

Signature of Health Care Provider: _____

Phone: (_____) _____ Fax: (_____) _____

Address: _____

City: _____ State: _____ Zip: _____