

In compliance to State of Tennessee Department of Health regulations, ALL students must complete Sections A and B; all full-time students and students living on campus must also complete Section C. Failure to provide proof of immunization will result in not being allowed to attend classes. New undergraduates will not be assigned housing until the completed form is received.

Section A: Student Information and Health Insurance

Full Name: _____ **Birthdate:** _____
Address: _____
City/State/Zip: _____
Email: _____
Primary Phone Contact: _____ Cell Home Other
Secondary Phone Contact: _____ Cell Home Other
Month and Year of Entry: _____ **Status:** Full-time Undergraduate
 Part-time Special Admission
Health Insurance Company: _____
 Policy Holder Name: _____ Policy #: _____

Section B: Required and Recommended Vaccinations

Required	Full-time students and any student living on campus	Recommended
	MMR Varicella Meningococcal (if under age 22 and living on campus)	Hepatitis B Polio DPT, DTaP, DT, Tdap Meningococcal (if living on campus)

The General assembly of the State of Tennessee mandates that each public or private postsecondary institution in the state provide information concerning the Hepatitis B infection to all students entering the institution for the first time. Those students who will be living in on-campus housing must also be informed about the risk of meningococcal meningitis infection. The required information below includes the risk factors and dangers of each disease as well as the availability and effectiveness of the respective vaccines for persons who are at risk for the diseases. The information concerning these diseases is from the Centers for Disease control (CDC) and the American College Health Association. For more information about these diseases and vaccines, please contact your local healthcare provider or visit the CDC website at www.cdc.gov/health/default.htm. **ALL STUDENTS are required to respond to the statements below and sign at the bottom.**

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. The disease is transmitted by blood and/or body fluids, and many people will have no symptoms when they develop the disease. The primary risk factors for hepatitis B are sexual activity and injection drug use. This disease is completely preventable with the Hepatitis B vaccine which is available to all age groups. 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 doses have been acquired. The HBV vaccine has a record of safety and is believed to confer lifelong immunity in most cases.

_____ I hereby certify that I have read this information about Hepatitis B (HBV) and **have elected not to receive the Hepatitis B vaccine.**

_____ I hereby certify that I read this information and **have received the initial dose of the Hepatitis B vaccine on** ___/___/___.

Meningococcal Disease is a rare but potentially fatal bacterial infection, expressed as either meningitis (infection of the membranes surrounding the brain and spinal cord) or meningococcemia (bacteria in the blood). Meningococcal disease strikes about 3,000 Americans each year and is responsible for about 300 deaths annually. The disease is spread by airborne transmission primarily by coughing. The disease can onset very quickly and without warning. Rapid intervention and treatment is required to avoid serious illness and/or death. There are five different subtypes (serogroups) of the bacterium that cause Meningococcal Meningitis. The current vaccine does not stimulate protective antibodies to Serogroups B, but it does protect against the most common strains of the disease including serogroups A, C, Y, and W-135. The duration of protection is approximately three to five years. The vaccination is very safe. Adverse reactions are mild and infrequent consisting primarily of redness at the injection site lasting up to two days. The Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) recommends that college freshman (particularly those who live in dormitories or residence halls) be informed about meningococcal disease and the benefits of vaccination and that those students who wish to reduce their risk for disease to be immunized. Any undergraduate students who wish to reduce their risk for disease may choose to be vaccinated.

_____ I hereby certify that I have read this information and **have elected not to receive the Meningococcal Meningitis vaccine.**

_____ I hereby certify that I have read this information and **have received the Meningococcal Meningitis vaccine on** ___/___/___.

Student signature: _____ Date: _____

Parent/Guardian signature if student under age 18: _____ Date: _____

Student Signature: _____ Birthdate: _____

Section C: Proof of Immunization

NOTICE: To be completed and signed by the **Healthcare Provider** or attach an official copy of your immunization records.

Vaccine	Date (mm/dd/yy)	Date (mm/dd/yy)	Date (mm/dd/yy)	Total Doses	In lieu of vaccination . . .		
					Serology Positive (mm/dd/yy)	Disease History (mm/yy)	Medical Exemption
Required MMR (Born after 1956, 2 doses OR + serology) Measles Mumps Rubella							
Varicella (Born after 1979, 2 doses OR + serology OR credible history of chicken pox)							
Meningococcal (MCV4) (1 Dose on or after 16 th birthday if under age 22)							
Recommended Hepatitis B (3 doses: Required for students in health science prior to patient care.)							
	Polio (Primary series)						
	Tetanus DPT, DTap, DT, Tdap (TD booster within 10 years)						

Tuberculosis SCREENING for International Students ONLY: Required to be done in the U.S. within the past 12 months. PPD placement, IGRA testing, x-ray, and appropriate treatment as deemed necessary by the Health Department or physician. A history of disease or BCG vaccination should not preclude testing of a member of a high risk group.

Screening Assessment (REQUIRED): Low Risk High Risk (additional testing required)
PPD Test: Date Given: ___/___/___ Date Test Read: ___/___/___ Result: _____ mm. Positive Negative
Chest X-ray (required for positive test): Positive Negative Date/duration of treatment: _____

Healthcare Provider Name:		Phone:	
Address:		City/State/Zip:	
Healthcare Provider Signature:		Date:	

Section D: Religious Exemption

NOTICE: Must be **notarized** if you decline required vaccinations due to religious beliefs and practices.

I understand that under Tennessee Law and/or Milligan College policy, newly enrolled traditional students are required to either be vaccinated against the below stated diseases or to obtain a medical or religious waiver from this law and/or policy. I have reviewed the CDC website information regarding the indicated immunizations at: <http://www.cdc.gov/vaccines/pubs/vis/default.htm> and understand the possible risks of not receiving immunizations include: becoming infected with the disease, death, transmitting vaccine-preventable disease to others, exclusion from school or house quarantine during an outbreak.

The following indicated immunization(s) is (are) prohibited by my religious beliefs and practices:

Measles Mumps Rubella Varicella Meningococcal Hepatitis B series

Student Signature Date If under 18, Parent/Guardian Signature Date

NOTARY PUBLIC: _____	NOTARY SEAL:
Date Commission Expires: _____	
Sworn and subscribed before this ____ day of _____, 20____.	