Immunization Instructions

Complete the following steps:

1. Print this page for reference.

2. If you have not already done so, activate your UT Student ID at: newvols.utk.edu/prep/student-id.

3. Go to tiny.utk.edu/portal and enter your UT Net ID and password.

4. Click on the “Immunization” tab at the top of the page, then click on “Enter Dates.”

5. Enter your immunization information as provided by your healthcare provider and then click “Submit.”

6. A pop-up message will appear directing you to next upload a paper/hard copy of your UT Immunization/TB Record** for verification purposes. If you are unable to upload the records, you may alternatively submit them by ONE of the following means:

   • Email: immunizations@utk.edu
   • Fax: 865-974-2000
   • Mail: Immunization Coordinator, University of Tennessee, Student Health Center, 1800 Volunteer Blvd., Knoxville, TN 37996-3102
   • Bring to orientation and drop off at the Student Health Center table.

   (** Your UT Immunization Record must be signed by a health care provider, or in lieu of their signature you may attach a copy of your official personal immunization record to the form. UT Immunization Exemption Forms only need to be submitted if applicable.)

7. Next, go back to the top of the patient portal homepage and click on the “Forms” tab.

8. Click on the “Tuberculosis Screening Questionnaire” and complete.

9. Click “Submit.” (Note: If additional tuberculosis assessment and testing is required of you, a notification will appear advising you that a “Tuberculosis Risk Assessment Form” must be completed and signed by your health care provider. Follow the instructions in the notification. Upon your health care provider’s completion of the “Tuberculosis Risk Assessment Form,” submit the form by one of the means listed in step 6 above.)

10. Remember, for verification purposes, you must also upload or submit a paper/hard copy of your “UT Immunization Record” and, if required, the “Tuberculosis Risk Assessment Form” as noted in steps 6 and 9 above.

Information regarding these and other immunizations may be viewed at the CDC website cdc.gov/vaccines.
## Immunization Records

### SECTION A (REQUIRED)  Completed by students

<table>
<thead>
<tr>
<th>Last Name:</th>
<th>First Name:</th>
<th>MI:</th>
<th>DOB (mm/dd/yy)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Semester of first UT enrollment (circle one):</th>
<th>Fall</th>
<th>Spring</th>
<th>Summer</th>
<th>YEAR:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

*Plan to live in on-campus housing? (circle one)  YES  NO  

Student 9-digit ID#:  

### SECTION B (REQUIRED)  Completed by health care provider  (enter all dates in MM/DD/YY format)

#### STATE OF TENNESSEE AND THE UNIVERSITY OF TENNESSEE IMMUNIZATION REQUIREMENTS

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>DATE</th>
<th>DATE</th>
<th>DATE</th>
<th>DATE</th>
<th>Diagnosed</th>
<th>Serology</th>
<th>History</th>
<th>Med. Exempt.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles, mumps, rubella (MMR)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella (VAR)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcal ACWY*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*NEW INCOMING STUDENTS LESS THAN 22 YEARS OF AGE WHO WILL BE RESIDING IN ON-CAMPUS HOUSING MUST HAVE DOCUMENTATION OF IMMUNIZATIONS GIVEN ON OR AFTER THEIR 16TH BIRTHDAY.*

| Hepatitis B (HBV)                            |      |      |      |      |           |          |         |              |
| Only required for health science students    |      |      |      |      |           |          |         |              |

### SECTION C  Immunizations recommended but not required

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>DATE</th>
<th>DATE</th>
<th>DATE</th>
<th>DATE</th>
<th>Serology</th>
<th>Med. Exempt.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human Papillomavirus (HPV)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcal Serogroup B</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Polio series completed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tetanus, Diphtheria, and Pertussis (TDAP)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Students are responsible to verify with their individual academic program for other immunization requirements that are not listed above.

Immunization requirements for full-time Tennessee college students may be viewed at [tn.gov./health/article/required-immunizations](https://tn.gov./health/article/required-immunizations).

(Required) Printed or stamped name, address, phone of qualified health care provider (MD, DO, Pa, advised practice nurse, or health department)

Certified by (signature/stamp)  

Date of Issue (mm/dd/yy)  

Information regarding these and other immunizations may be viewed at [cdc.gov/vaccines](https://www.cdc.gov/vaccines).
Tuberculosis (TB) Screening Questionnaire

This form must be submitted to the Student Health Center as part of the registration process.

Student’s Last Name ____________________________ First Name ________________ Middle Name __________

Date of Birth ___________________ Student ID # __________________________

Please answer the following questions (circle yes or no):

1. Have you ever had close contact with anyone who was sick with TB? Yes No

2. Were you born in one of the countries listed below? Yes No

3. Have you ever traveled* to/in one or more of the countries listed below? Yes No

4. Have you been a resident, employee, or volunteer in a prison, homeless shelter, nursing home, or other high-risk congregate setting? Yes No

5. Have you been a member of an “at-risk” group—medically underserved/low income/drug or alcohol abusers? Yes No

6. Have you been a health care worker/volunteer serving clients at risk for active TB? Yes No

*Significance of travel exposure should be discussed with a health care provider and evaluated.

If the answer is YES to any of the above questions, the University of Tennessee also requires that a health care provider complete and return the enclosed Tuberculosis Risk Assessment Form (page 4), along with the completed questionnaire, to the Student Health Center prior to your scheduled orientation visit. Answering “yes” to any question will not prevent enrollment. All tuberculosis testing to be accepted must be done six months prior to the first day of classes.

If the answers to all the above questions are NO, further evaluation is not required; however, this completed questionnaire must be returned to the Student Health Center prior to or at the time of your orientation visit.

STUDENT SIGNATURE (REQUIRED) ____________________________ DATE ________________

Afghanistan  Chad  Guyana  Mali  Marshall Islands  Mauritania  Peru
Algeria  China  Haiti  Marshall Islands  Mauritania  Philippines  Portugal
Angola  Colombia  Honduras  Mauritius  Mexico  Qatar  Russia
Argentina  Comoros  India  Micronesia  Moldova  Romania  Rwanda
Armenia  Congo  Indonesia  Morocco  Mozambique  Russia  Saudi Arabia
Azerbaijan  Côte d’Ivoire  Iraq  Myanmar  Namibia  Senegal  Senegal
Belarus  Democratic Republic of the Congo  Kazakhstan  Namibia  Serbia  Serbia
Bangladesh  Djibouti  Kenya  Nepal  South Africa  Singapore  Singapore
Bosnia & Herzegovina  Dominican Republic  Kiribati  Nicaragua  Somaliland  Solomon Islands  Spain
Botswana  Ecuador  Korea-DPR  Mongolia  South Sudan  South Sudan  Spanish
Brazil  El Salvador  Korea-Republic  Montenegro  Sudan  Sudan
Bulgaria  Eritrea  Kyrgyzstan  Namibia  Tajikistan  Tanzania  Tajikistan
Burkina Faso  Ethiopia  Lao PDR  Nauru  Timor-Leste  Turkmenistan  Tunisia
Burundi  Fiji  Latvia  Nepal  Tuvalu  Uganda  Uganda
Cambodia  Gabon  Lesotho  Nicaragua  United Arab Emirates  Ukraine  Uruguay
Cameroon  Georgia  Liberia  Niger  United States of America  United Kingdom  Uzbekistan

*Source: World Health Organization, Global Health Observatory, Tuberculosis Incidence. Countries with incidence rates of >20 cases per 100,000 population, 2017.
Tuberculosis (TB) Risk Assessment Form

Student’s Last Name __________________________ First Name __________________________ Middle Name ________

Date of Birth __________________ Student ID # __________________________

To Health Care Provider:

This student’s responses on our TB Screening Questionnaire confirm an increased risk for TB infection. The following information is therefore required to complete their registration process for the university. All indicated testing must be performed within the six months prior to the first day of the student’s first semester of classes.

1. Risk Factors for Infection (Review with patient. If any “Yes,” proceed to #2. If all “No,” proceed to #5.)

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Prior positive TB test</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Recent close contact with someone with infectious TB disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Born outside of the United States (or travel* to/in) a high-prevalence area (e.g., Africa, Asia, Eastern Europe, or Central or South America)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Fibrotic changes on a prior chest x-ray suggesting inactive or past TB disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. HIV/AIDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Organ transplant recipient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G. Immunosuppressed (equivalent of &gt; 15 mg/day of prednisone of &gt; 1 month or TNF-antagonist)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H. History of illicit drug use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I. Resident, employee, or volunteer in a high-risk congregate setting (e.g., correctional facilities, nursing homes, homeless shelters, hospitals, and other health care facilities)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>J. Medical condition associated with increased risk of progressing to TB disease if infected [e.g., diabetes mellitus; silicosis; head, neck, or lung cancer; hematologic or reticuloendothelial disease, such as Hodgkin’s disease or leukemia; end-stage renal disease; intestinal bypass or gastrectomy; chronic malabsorption syndrome; or low body weight (i.e., 10% or more below ideal for the given population)]</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*The significance of the travel exposure should be discussed with a health care provider and evaluated for testing necessity.

Review with patient. If the answer to any of the above questions was “Yes,” proceed to #2. If all “No,” proceed to #5.

2. Does the student have signs of symptoms of active TB, e.g. fever, night sweats, hemoptysis, prolonged cough, or weight loss? Yes No

If yes, proceed with testing as indicated (e.g. TST or IGRA, chest x-ray, sputum AFB smear and cultures). Ongoing treatment for TB will not prevent the student’s enrollment.

If no, proceed to #3.

3. Tuberculin Skin Test (TST) OR Interferon Gamma Release Assay (IGRA)

Do not use TST within four weeks of a live virus vaccine.

TST result should be recorded as actual millimeter of induration, transverse diameter; if no induration, write “0.” The TST interpretation should be based on millimeter of duration as well as risk factors. See page 5.**

TST: Date Given ______ / ______/ ______ Result: ______mm of induration.

Date Given ______ / ______/ ______ **Interpretation: Negative / Positive

See next page for additional questions.
Interferon Gamma Release Assay (IGRA)

Date Obtained: _______ / _______ / _______
(Specify Method) QFT-G   QFT-GIT   T-Spot   Other______
Result:   Negative / Positive / Intermediate / Indeterminate

4. Chest x-ray (required within six months prior to start of classes for recent or prior positive TST or IGRA)

Date Obtained: _______ / _______ / _______
Result:   Normal / Abnormal

5. Please circle “No Risk” or “Risk” below regarding TB infections.
A. No Risk
B. Risk (Please attach information regarding past/present treatment for latent/active TB infection.)

6. Health Care Provider Contact Information (sign only when testing completed)

Provider’s Name__________________________________________________________________________________
Address_________________________________________________________________________________________
City ____________________________ State_____ Zip Code _____________ Country_________________________
Phone Number ___________________ Fax Number __________________________
Provider’s Signature_________________________________________________________ Date ________________

** TST Interpretation Guidelines

>5 mm is positive in:
• Recent close contacts of an individual with infectious TB
• Persons with fibrotic changes on a prior chest x-ray consistent with past TB disease
• Organ transplant recipients
• Immunosuppressed persons: taking > 15 mg/d of prednisone for > 1 month; taking a TNF-a antagonist
• Persons with HIV/AIDS

> 10 mm is positive in:
• Persons born in a high-prevalence country or who resided in one for a significant* amount of time
• History of illicit drug use
• Mycobacteriology laboratory personnel
• History of resident, worker, or volunteer in high-risk congregate settings
• Persons with the following: silicosis; diabetes mellitus; chronic renal failure; leukemias and lymphomas; gastrectomy or intestinal bypass; head, neck, or lung cancer; low body weight (>10% below ideal); and/or chronic malabsorption syndromes

> 15 mm is positive in:
• Persons with no known risk factors for TB disease

*The significance of travel exposure should be discussed with a health care provider and evaluated.

Health care provider: Please return this completed two-page form to the address listed below. It must be received in our office prior to the first day of the student’s first semester of classes or a “hold” will be placed on their account.

Immunization Coordinator
Student Health Center
University of Tennessee
1800 Volunteer Blvd.
Knoxville, TN 37996
Immunization Exemption Form

Student’s Last Name ___________________________ First Name ___________________ Middle Name _______

Date of Birth ___________________ Student ID # __________________________

I understand that under Tennessee law and/or University of Tennessee, Knoxville, policy, newly enrolled students in a Tennessee Institution of higher education are required to either be vaccinated against the below stated diseases or to obtain a medical or religious waiver from this law. I have reviewed the CDC website information regarding the indicated immunizations at 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.

MEDICAL EXEMPTION

The following indicated immunization(s) is/are medically contraindicated for this student:

___ Measles     ___ Varicella     ___ Other ______________________________
___ Mumps       ___ Hepatitis B Series
___ Rubella     ___ Meningitis

Reason for Exemption __________________________________________________________

This Exemption shall continue until ______________________________________________

Signature of Physician ________________________________________________________

Date _______________________________________________________________________

Printed Name of Physician ____________________________________________________

License #______________________________

Address of Physician _________________________________________________________

City, State, Zip _______________________________________________________________

RELIGIOUS EXEMPTION

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

___ Measles     ___ Varicella     ___ Other ______________________________
___ Mumps       ___ Hepatitis B Series
___ Rubella     ___ Meningitis

Student’s Signature ___________________________________________________________

Date ________________

Printed Name of Parent/Guardian ______________________________________________

Signature of Parent/Guardian __________________________________________________

Date ________________

Important: If the student is under age 18, a parent/guardian must also sign this waiver.