THE UNIVERSITY OF
TENNESSEE
KNOXVILLE

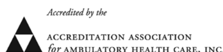
STUDENT HEALTH CENTER

For enrollment purposes, the University of Tennessee, Knoxville, and/or the State of Tennessee *mandate* newly admitted students meet and submit proof of certain immunizations and tuberculosis (TB) screening requirements. Active service members or veterans attending UT can submit their Military ID or DD 214 to clear the immunization requirements.

- The Immunization/Tuberculosis Packet must be submitted to the Student Health Center, preferably online (see attached instructions) or by postal service.
- Deadlines: Fall semester—August 1; Spring semester—January 1
- If not compliant, an immunization hold* will be placed on the MyUTK student account.
- If not compliant, the student will not be permitted to move into on-campus housing until completed.
- Have your health care provider complete and sign the required forms or attach a copy of your vaccination records. Tuberculosis screening must be competed and submitted online (preferable) or by postal service.
- Confirmation emails will be sent to students' UT email account upon receipt.
- Additional information regarding the immunizations/tuberculosis screening requirements may be obtained at: ***tiny.utk.edu/immunization*** or by calling 865-974-3135.

Information regarding these and other immunizations may be viewed at the CDC website: ***cdc.gov/vaccines***.

**Immunization hold means a student will not be eligible to change their class schedule, receive grades, register for the next semester, or graduate until all immunization requirements have been met and the hold released.*



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***.

REVISED 5/17

Immunization Records

SECTION A (REQUIRED) *Completed by students*

Last Name: ____________ First Name: ____________ MI: ______ DOB (mm/dd/yy) ____________

Semester of first UT enrollment (circle one): Fall Spring Summer YEAR:

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

Student 9-digit ID#: 000

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

VACCINE	DATE	DATE	DATE	DATE	Diagnosed	Serology	History	Med. Exempt.
Measles, mumps, rubella (MMR)								
Varicella (VAR)								
Meningococcal ACWY*								
***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*

VACCINE	DATE	DATE	DATE	DATE		Serology		Med. Exempt.
Hepatitis A								
Human Papillomavirus (HPV)								
Meningococcal Serogroup B								
Primary Polio series completed								
Tetanus, Diphtheria, and Pertussis (TDAP)								

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***.

(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***.

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
Algeria
Angola
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia
Bosnia & Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
Central African Rep.
Chad
China
Colombia
Comoros
Congo
Cote d'Ivoire
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Ethiopia
Fiji
Gabon
Gambia
Georgia
Ghana
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Kazakhstan
Kenya
Kiribati
Korea-DPR
Korea-Republic
Kuwait
Kyrgyzstan
Lao PDR
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Mexico
Micronesia
Moldova
Mongolia
Montenegro
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Portugal
Qatar
Romania
Russian Federation
Rwanda
Sao Tome & Principe
Senegal
Serbia
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Swaziland
Syrian Arab Republic
Tajikistan
Thailand
Timor-Leste
Togo
Tunisia
Turkmenistan
Tuvalu
Uganda
Uganda
Ukraine
United Republic of Tanzania
Uzbekistan
Vanuatu
Venezuela
Viet Nam
Yemen
Zambia
Zimbabwe

*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.)

A. Prior positive TB test	Yes	No
B. Recent close contact with someone with infectious TB disease	Yes	No
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)	Yes	No
D. Fibrotic changes on a prior chest x-ray suggesting inactive or past TB disease	Yes	No
E. HIV/AIDS	Yes	No
F. Organ transplant recipient	Yes	No
G. Immunosuppressed (equivalent of > 15 mg/day of prednisone of > 1 month or TNF-antagonist)	Yes	No
H. History of illicit drug use	Yes	No
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)	Yes	No
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)]	Yes	No

**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.

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REVISED 5/17