THE UNIVERSITY OF TENNESSEE KNOXVILLE

STUDENT HEALTH CENTER

Immunization/Tuberculosis Packet

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.

Immunizations must be submitted to the Student Health Center online using the Student Health patient portal.

1. Navigate to the Student Health Portal at ***tiny.utk.edu/portal***
2. Enter your UTK Net ID and Password.
3. Click on the "Immunization" tab at the top of the page. Click the "Required" and "Recommended" tabs to enter dates. Enter your immunization information as provided by your healthcare provider and then click "Submit."
4. A pop-up message will appear directing you to next upload a paper/hard copy of your UTK Immunization/TB Record for verification purposes.
   - Your UTK Immunization/TB Record must be signed by a healthcare provider or in lieu of their signature you may attach a copy of your official, personal immunization record to the form. UTK Immunization Exemption Forms only need to be submitted if applicable.
5. Confirmation emails will be sent to your UTK email ***YourNetID@vols.utk.edu*** upon receipt. Please allow 72 hours for approval.

If you are unable to submit your immunizations online, please print the Immunization/Tuberculosis Packet.

Have your health care provider complete and sign the required forms or attach a copy of your vaccination records and submit it to the Student Health Center 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

Additional information regarding the immunizations/ tuberculosis screening requirements may be obtained at ***tiny.utk.edu/immunization*** or by calling 865-974-3135.

Deadlines:

- Fall semester—August 1
- Spring semester—January 1
- Summer semester—May 1

If you are not compliant:

- An immunization hold will be placed on your MyUTK account, and you will not be eligible to change your class schedule, receive grades, register for the next semester, or graduate until all immunization requirements have been met and the hold is released.
- You will not be permitted to move into on-campus housing until completed.

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

Accredited by the ACCREDITATION ASSOCIATION *for* AMBULATORY HEALTH CARE, INC.

REVISED 4/15/2022

University of Tennessee Health Services
Certificate of Immunization

Student ID: 000

STUDENT PLEASE COMPLETE ALL OF THE FOLLOWING INFORMATION

Last Name_____ First Name_____ MI:_____

Date of Birth (mm/dd/yyyy): _____ Student Cell Phone Number: _____

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

Have you completed the TB (Tuberculosis) Questionnaire?
See website for details: **studenthealth.utk.edu**
Click on the + next to Immunization Requirements

INSTRUCTIONS:

- **PROVIDERS*: YOUR SIGNATURE OR STAMP IS REQUIRED IN EACH CORRESPONDING BOX**
- **Page 1: REQUIRED immunizations** **Page 2: RECOMMENDED (but not required) immunizations**
- UTK Student ID number (beginning with three leading zeroes) must appear at the top of each page
- Immunization information must be completed AND signed by a healthcare provider
- Alternately, a copy of your medical records, which includes your immunization information, may be submitted
- Medical Exemptions documenting contraindication of vaccinations or alternate proof of immunity (i.e. titer test results) or Religious Exemptions may be submitted.
- Forms, as proof, must be submitted and approved in order to register for classes at the University of Tennessee
- After submission, check your **@utk.edu** email for important notifications regarding immunization status
- Keep a copy for your records

PROVIDERS:
PLEASE STAMP OR SIGN EACH BOX BELOW

THE FOLLOWING IMMUNIZATIONS ARE REQUIRED

VACCINE	REQUIREMENTS	DATE OF DOSE, DISEASE, OR TITER (with results) MM/DD/YYYY	HEALTHCARE PROVIDER SIGNATURE/STAMP REQUIRED IN EACH BOX
MMR® (2 Doses) (Measles, Mumps, Rubella) **ALL STUDENTS SEE REQUIREMENTS TO THE RIGHT**	**All** students born on or after January 1, 1957 must provide proof of one of the following: (i) 2 doses of MMR vaccine at least 28 days apart **OR** (ii) Serology (titer) showing immunity	DOSE 1: _____ DOSE 2: _____ TITER: POSITIVE/NEGATIVE (ATTACH TITER RESULTS)	AFFIX STAMP OR SIGNATURE
VARICELLA (2 doses) (Varivax®) **ALL STUDENTS SEE REQUIREMENTS TO THE RIGHT**	**All** students born on or after January 1, 1980 must provide proof of one of the following: (i) 2 doses of VARICELLA vaccine at least 28 days apart **OR** (ii) Serology (titer) showing immunity (iii) Medical documentation of disease from a healthcare provider	DOSE 1: _____ DOSE 2: _____ DATE OF ILLNESS: _____ TITER: POSITIVE/NEGATIVE (ATTACH TITER RESULTS)	AFFIX STAMP OR SIGNATURE
MENINGITIS ACWY (Meningococcal) (Menactra® or Menveo®) **STUDENTS LIVING ON CAMPUS, SEE REQUIREMENTS TO THE RIGHT**	All new incoming students younger than 22 years of age and who will be **living in on-campus housing** must have documentation of a dose of quadrivalent conjugate vaccine (MCV4 protects against strains **A, C, W135, and Y**) ON or AFTER turning 16 years of age. Any student not living on campus who has not been immunized within the last five (5) years may choose to do so to reduce the risk of meningococcal disease	**THE DATE OF THE MOST RECENT DOSE MUST FALL ON/AFTER THE DATE THE STUDENT TURNED 16 YEARS OF AGE** DOSE: _____	AFFIX STAMP OR SIGNATURE

University of Tennessee Health Services
Certificate of Immunization

Student ID: 0 0 0 | | | | | | | |

The following immunizations are RECOMMENDED but NOT REQUIRED

VACCINE	REQUIREMENTS	DATE OF DOSE, DISEASE, OR TITER (with results) MM/DD/YYYY	HEALTHCARE PROVIDER SIGNATURE/STAMP
COVID-19 (CIRCLE ONE) **PFIZER** **MODERNA** **JANSSEN J&J** **OTHER:**_____	Recommended; not required	DOSE 1: _____ DOSE 2: _____ BOOSTER: _____ BOOSTER: _____	AFFIX STAMP OR SIGNATURE
INFLUENZA	Recommended; not required	DOSE 1: _____	AFFIX STAMP OR SIGNATURE
HEPATITIS B® (3 DOSES) For information on Hepatitis B, refer to the Center for Disease Control and Prevention website. All Health Science students must provide proof: (i)3 doses of HEPATITIS B (ii)Serology (titer) showing positive (+) results	Recommended; not required **EXCEPT** Required for ALL Health Science students; must provide proof of: (i) 3 doses of HEPATITIS B **OR** (ii) Serology (titer) showing positive (+) results	DOSE 1: _____ DOSE 2: _____ DOSE 3: _____ TITER: POSITIVE/NEGATIVE (ATTACH TITER RESULTS)	AFFIX STAMP OR SIGNATURE
TETANUS OR TDAP (Adacel® or Boostrix®) This vaccine can help prevent tetanus disease, commonly known as "lockjaw," a serious disease that causes painful tightening of the muscles in the jaw and sometimes in other parts of the body. TdaP also contains protection from Pertussis (whooping cough)	Recommended within the last 10 years	☐ TETANUS **OR** ☐ TdaP DOSE: _____	AFFIX STAMP OR SIGNATURE
HEPATITIS A	Recommended; not required	DOSE 1: _____ DOSE 2: _____	AFFIX STAMP OR SIGNATURE
HUMAN PAPILLOMAVIRUS (HPV)	Recommended; not required	DOSE 1: _____ DOSE 2: _____ DOSE 3: _____	AFFIX STAMP OR SIGNATURE
MENINGOCOCCAL SEROGROUP B (Bexsero® or Trumemba®)	Recommended; not required	DOSE 1: _____ DOSE 2: _____	AFFIX STAMP OR SIGNATURE
POLIO (primary) SERIES	Recommended; not required	DATE SERIES COMPLETED: _____	AFFIX STAMP OR SIGNATURE

PROVIDER'S NAME:_____ PHONE NUMBER: _____

ADDRESS:_____ CITY: _____ STATE:_____ ZIP:_____

PROVIDER'S SIGNATURE:_____ DATE: _____

FOR HELPFUL IMMUNIZATION GUIDELINE INFORMATION

Center for Disease Control and Prevention: ***cdc.gov/vaccines/schedules***

Tennessee State Health Department: ***tn.gov/health/cedep/immunization-program***

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Tuberculosis (TB) 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
Anuilla
Argentina
Armenia
Azerbaijan
Bahamas
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia & Herzegovina
Botswana
Brazil
Brunei Darussalam
Burkina Faso
Burundi
CÃ´te d'Ivoire
Cabo Verde
Cambodia
Cameroon
Central African Rep.
Chad
China
China, Hong Kong SAR
China, Macao SAR
Colombia
Comoros
Congo
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominica
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Eswatini
Ethiopia
Fiji
French Polynesia
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Kazakhstan
Kenya
Kiribati
Kyrgyzstan
Lao People's Dem. Rep.
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Malta
Marshall Islands
Mauritania
Mexico
Micronesia (Fed. States of)
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Niue
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Sao Tome & Principe
Senegal
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Tajikistan
Thailand
Timor-Leste
Togo
Tokelau
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Rep. of)
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, 2020.

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 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