



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

Mall 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.

University of Tennessee Health Services Certificate of Immunization

Student ID:

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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:

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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	<input type="checkbox"/> TETANUS OR <input type="checkbox"/> 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](https://www.cdc.gov/vaccines/schedules)

Tennessee State Health Department: [tn.gov/health/cedep/immunization-program](https://www.tn.gov/health/cedep/immunization-program)

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

*Source: World Health Organization, Global Health Observatory, Tuberculosis Incidence.

Countries with incidence rates of >20 cases per 100,000 population, 2023.

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

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