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
University of Tennessee Health Services Certificate of Immunization

**STUDENT** PLEASE COMPLETE ALL OF THE FOLLOWING INFORMATION

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Date of Birth (mm/dd/yyyy)</th>
<th>Student Cell Phone Number</th>
</tr>
</thead>
</table>

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

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**THE FOLLOWING IMMUNIZATIONS ARE REQUIRED**

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>REQUIREMENTS</th>
<th>DATE OF DOSE, DISEASE, OR TITER (with results) MM/DD/YYYY</th>
<th>HEALTHCARE PROVIDER SIGNATURE/STAMP REQUIRED IN EACH BOX</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMR* (2 Doses)</td>
<td>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</td>
<td>DOSE 1: ___________ DOSE 2: ___________ TITER: POSITIVE/NEGATIVE (ATTACH TITER RESULTS)</td>
<td>AFFIX STAMP OR SIGNATURE</td>
</tr>
<tr>
<td>VARICELLA (2 doses)</td>
<td>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</td>
<td>DOSE 1: ___________ DOSE 2: ___________ DATE OF ILLNESS: ___________ TITER: POSITIVE/NEGATIVE (ATTACH TITER RESULTS)</td>
<td>AFFIX STAMP OR SIGNATURE</td>
</tr>
<tr>
<td>MENINGITIS ACWY</td>
<td>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</td>
<td>THE DATE OF THE MOST RECENT DOSE MUST FALL ON/AFTER THE DATE THE STUDENT TURNED 16 YEARS OF AGE</td>
<td>AFFIX STAMP OR SIGNATURE</td>
</tr>
</tbody>
</table>

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**PROVIDERS:** PLEASE STAMP OR SIGN EACH BOX BELOW
The following immunizations are **RECOMMENDED** but **NOT REQUIRED**

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>REQUIREMENTS</th>
<th>DATE OF DOSE, DISEASE, OR TITER (with results) MM/DD/YYYY</th>
<th>HEALTHCARE PROVIDER SIGNATURE/STAMP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COVID-19 (CIRCLE ONE)</strong></td>
<td></td>
<td></td>
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<tr>
<td>PFIZER</td>
<td>Recommended; not required</td>
<td>DOSE 1: ___________________</td>
<td>AFFIX STAMP OR SIGNATURE</td>
</tr>
<tr>
<td>MODERNA</td>
<td></td>
<td>DOSE 2: ___________________</td>
<td></td>
</tr>
<tr>
<td>JANSSEN J&amp;J</td>
<td></td>
<td>BOOSTER: ___________________</td>
<td></td>
</tr>
<tr>
<td>OTHER:</td>
<td></td>
<td>BOOSTER: ___________________</td>
<td></td>
</tr>
<tr>
<td><strong>INFLUENZA</strong></td>
<td></td>
<td>DOSE 1: ___________________</td>
<td>AFFIX STAMP OR SIGNATURE</td>
</tr>
<tr>
<td><strong>HEPATITIS B</strong> (3 DOSES)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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</td>
<td>Recommended within the last 10 years</td>
<td>Excluding students who have tested positive for HCV</td>
<td></td>
</tr>
<tr>
<td>EXCEPT</td>
<td></td>
<td>DOSE 1: ___________________</td>
<td>AFFIX STAMP OR SIGNATURE</td>
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<tr>
<td></td>
<td></td>
<td>DOSE 2: ___________________</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>DOSE 3: ___________________</td>
<td></td>
</tr>
<tr>
<td>TITERT: POSITIVE/NEGATIVE (ATTACH TITER RESULTS)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TETANUS OR Tdap</strong> (Adacel® or Boostrix®)</td>
<td>Recommended within the last 10 years</td>
<td>TETANUS OR Tdap</td>
<td>AFFIX STAMP OR SIGNATURE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DOSE: ___________________</td>
<td></td>
</tr>
<tr>
<td><strong>HEPATITIS A</strong></td>
<td></td>
<td>DOSE 1: ___________________</td>
<td>AFFIX STAMP OR SIGNATURE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DOSE 2: ___________________</td>
<td></td>
</tr>
<tr>
<td><strong>HUMAN PAPILLOMAVIRUS (HPV)</strong></td>
<td></td>
<td>DOSE 1: ___________________</td>
<td>AFFIX STAMP OR SIGNATURE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DOSE 2: ___________________</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>DOSE 3: ___________________</td>
<td></td>
</tr>
<tr>
<td><strong>MENINGOCOCCAL SERO GROUP B</strong></td>
<td>Recomended within the last 10 years</td>
<td>DOSE 1: ___________________</td>
<td>AFFIX STAMP OR SIGNATURE</td>
</tr>
<tr>
<td>(Bexsero® or Trumemba®)</td>
<td></td>
<td>DOSE 2: ___________________</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>DOSE 3: ___________________</td>
<td></td>
</tr>
<tr>
<td><strong>POLIO</strong> (primary) SERIES</td>
<td>Recommended; not required</td>
<td>DOSE 1: ___________________</td>
<td>AFFIX STAMP OR SIGNATURE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DOSE 2: ___________________</td>
<td></td>
</tr>
<tr>
<td></td>
<td>DATE SERIES COMPLETED: ___________________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**FOR HELPFUL IMMUNIZATION GUIDELINE INFORMATION**
Center for Disease Control and Prevention: [cdc.gov/vaccines/schedules](http://cdc.gov/vaccines/schedules)
Tennessee State Health Department: [tn.gov/health/cedep/immunization-program](http://tn.gov/health/cedep/immunization-program)

**PROVIDER’S NAME: ______________________ PHONE NUMBER: ______________________

**ADDRESS: ______________________ CITY: ______________________ STATE: ________ ZIP: ________

**PROVIDER’S SIGNATURE: ______________________ DATE: ______________________

**Student ID: ________**
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 ___________________________


*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.)

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