EAST TENNESSEE STATE UNIVERSITY

Immunization Form

University Health Center
Box 70675 Johnson City, TN 37614 -- Located in Roy S. Nicks Hall Ste. 160
Phone: 423-439-4225 Fax: 423-439-4560 Email: floram@etsu.edu
More Information: www.etsu.edu/immunizations

All information must be completed in full, written legibly in English, and completed in ink

It is highly recommended the Immunization Form be received 30 days prior to your on campus orientation or registration.

Name:_____
Last/Surname *First/Given* *Middle Name*

*Date of Birth: __/__/____ *Month/Day/Year (ex. 01/20/1999)* ETSU Student ID #:_____

ETSU Email:_____ Plan to live in On-Campus Housing? YES____ NO ____

Semester of first ETSU Enrollment (circle one): Fall Spring Summer Year:_____

Immunization Requirements for Full-Time Students:

Two doses of MMR & **Two** doses of Varicella (Chickenpox) **or** a titer quantitative lab report(serology proof, IgG antibodies of immunity of diseases), or medical provider documentation verifying previous diagnosis of disease and date of disease (mm/day/year) If submitting titer reports, please attach to this form. *Students under the age of 22 and living in on-campus housing are required to have a Meningococcal Vaccine (MEN-ACWY) within the past 5 years.

This section to be completed and signed by a Licensed Medical Provider or Health Department Medical Staff.
Please attach supporting medical documentation regarding immunizations.

VACCINE All dates must be in **Month/Day/Year** (*ex. 01/20/1999*)	**1st DOSE** (must be given after 1st birthday) *(mm/day/year)*	**2nd DOSE** (given at least 28 days after 1st dose) *(mm/day/year)*	**Date of Disease** *(mm/day/year)* **(no vaccines)**
Varicella Vaccine (Chickenpox)	--/--/----	--/--/----	--/--/----
MMR Combined	--/--/----	--/--/----	
Measles (only)	--/--/----	--/--/----	
Mumps (only)	--/--/----	--/--/----	
Rubella (only)	--/--/----	--/--/----	
*Meningococcal-ACWY (Within last 5 years)	--/--/----	--/--/----	

Email:floram@etsu.edu
Fax: 423-439-4560

Place Clinic Stamp Here:

Medical Provider Information:

Name/ Title (Print): _____ **NPI:**_____

Address: _____ **Phone #:**_____

Provider Signature:_____ **Date:** _____

Exemption form for religious purposes or for medical contraindications do not use this form.
(Please see the University Health Center website for all accepted forms.)