

_____/_____/_____
Last First Middle Suffix Birthday (MM/DD/YYYY)
_____-_____-_____
(_____) _____ - _____ - _____
Cell or Home Phone Number Social Security Number

Under the Tennessee Department of Health guidelines, all full-time, non-distance learning students at Cumberland University must present proof of adequate immunization against the following diseases

- (a) Measles* (b) Mumps* (c) Rubella * (d) Varicella **

*** For Student born on or after January 1, 1957**

**** For Student born on or after January 1, 1980**

A full-time student is an undergraduate enrolled in at least twelve (12) semester hours or the equivalent or a graduate student enrolled in at least nine (9) semester hours or the equivalent.

Additionally, any student who is a health science student expected to have patient contact shall present proof of protection against Hepatitis B before patient contact begins. Adequate immunization is defined as a complete hepatitis B vaccine series; or laboratory evidence of immunity or infection.

Lastly, Cumberland University requires all students who reside in any Cumberland University Residence Hall to have the meningococcal vaccine, as suggested by the Tennessee Department of Health.

A student may be exempted from the requirements of Cumberland's Vaccination Policy only under the following circumstances:

- (a) *Where a physician licensed by a Board of Medical Examiners, a Board of Osteopathic Examiners or a Health Department determines that a particular vaccine is contraindicated for one of the following reasons :*
- 1. The individual meets the criteria for contraindication set forth in the manufacturer's vaccine package insert; or*
 - 2. The individual meets the criteria for contraindication published by the U.S. Centers for Disease Control or the ACIP;*
 - 3. In the best professional judgment of the physician, based upon the individual's medical condition and history, the risk of harm from the vaccine outweighs the potential benefit.*
- (b) *An individual who has been exempted from a particular vaccination must comply with immunization requirements for any vaccines from which he/she has not been exempted.*
- (c) *Where a parent or guardian, or in the case of an adult student, the student, provides to the school a written statement, affirmed under penalties of perjury, that vaccination conflicts with the religious tenets and practices of the parent or guardian, or in the case of an adult student, the student.*

Students and/or a parent or guardian seeking exemption from one or more of the vaccinations required by either the State of Tennessee and/or Cumberland University should contact the Office of Admissions for a copy of the Medical Vaccination Waiver Form.

For students not seeking an exemption, please have your medical provider complete the reverse side of this form.

RETURN TO:

Office of Admissions, Cumberland University, 1 Cumberland Square, Lebanon, TN 37087

PLEASE PRINT

Student Information

| | | | | |
|------|-------|--------|--------|--|
| Last | First | Middle | Suffix | _____/_____/_____ Birthday (MM/DD/YYYY) |
|------|-------|--------|--------|--|

To be completed by a physician, medical clinic, or health department official

I hereby attest that the above named student has received the following vaccinations on the dates listed as required by the Tennessee Department of Health for enrollment at an Institution of higher education.

For all full-time students:

| | | |
|-----------|--------------------------------------|--|
| Measles | Vaccination administered on | _____/_____/_____ Month Day Year |
| Mumps | Vaccination administered on | _____/_____/_____ Month Day Year |
| Rubella | Vaccination administered on | _____/_____/_____ Month Day Year |
| Varicella | History of Varicella | _____/_____ Month Year |
| | OR | |
| | 1 st Dose administered on | _____/_____/_____ Month Day Year |
| | 2 nd Dose administered on | _____/_____/_____ Month Day Year |

Required for all residential students: (non-residential students may submit a medical vaccination waiver form)

| | | |
|-----------------------|-----------------------------|---|
| Meningococcal Disease | Vaccination administered on | _____/_____/_____ Month Day Year |
|-----------------------|-----------------------------|---|

Required for all health science students:

| | | |
|-------------|--------------------------------------|---|
| Hepatitis B | 1 st Dose administered on | _____/_____/_____ Month Day Year |
| | 2 nd Dose administered on | _____/_____/_____ Month Day Year |
| | 3rd Dose administered on | _____/_____/_____ Month Day Year |

Place Health Clinic or Physician's Office Stamp Here

 Physician or Authorized Signature

 _____/_____/_____
 Date Form Completed