Cumberland UNIVERSITY

PLEASE PRINT

Office of Admissions
Proof of Medical Vaccinations

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:

Dose 1- MMR: Measles, Mumps, Rubella — Vaccination administered on _____/_____/_____ (Month Day Year)

Dose 2- MMR: Measles, Mumps, Rubella — Vaccination administered on _____/_____/_____ (Month Day Year)

Varicella — History of Varicella _____/_____ (Month Year)

OR

1st Dose administered on _____/_____/_____ (Month Day Year)

2nd 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)

Meningococcal Booster (Optional) — Vaccination administered on _____/_____/_____ (Month Day Year)

Required for all health science students

Hepatitis B — 1st Dose administered on _____/_____/_____ (Month Day Year)

2nd 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

RETURN TO: *Office of Admissions, 1 Cumberland Square, Lebanon, TN 37087 or fax to (615) 547-1256*