EMMANUEL CHRISTIAN SEMINARY AT MILLIGAN

Emmanuel Christian Seminary
Proof of Immunization Record

***NOTICE**: To comply with the **State of Tennessee Department of Health regulations**, all students must provide proof of immunization as requested per this form. **Failure to provide proof of immunization will result in not being allowed to attend class, and/or have access to campus housing**.*

Section A: Student Information and Health Insurance

Full Name: _____ **Birthdate**: _____

Address: _____

City/State/Zip: _____

Email: _____

Primary Phone Contact: _____ □ Cell □ Work □ Home □ Other

Secondary Phone Contact: _____ □ Cell □ Work □ Home □ Other

Month and Year of Entry: _____ **Status**: □ Full-time □ Part-time □ Graduate □ Undergraduate

Health Insurance Company: _____

Policy Holder Name: _____ Policy #: _____

Section B: Notice of Required and Recommended Vaccinations

Required (All Full-Time Students)	**Recommended**
MMR Varicella Meningococcal (if under age 22 and living on campus)	Hepatitis B Polio DPT, DTaP, DT, Tdap Meningococcal (if living on campus)

The General assembly of the State of Tennessee mandates that each public or private postsecondary institution in the state provide information concerning the Hepatitis B infection to all students entering the institution for the first time. Those students who will be living in on-campus housing must also be informed about the risk of meningococcal meningitis infection. The required information below includes the risk factors and dangers of each disease as well as the availability and effectiveness of the respective vaccines for persons who are at risk for the diseases. The information concerning these diseases is from the Centers for Disease control (CDC) and the American College Health Association. For more information about these diseases and vaccines, please contact your local healthcare provider or visit the CDC website at www.cdc.gov/health/default.htm. **All students are required to respond to the statements below and sign accordingly.**

Hepatitis B (HBV) is a serious viral infection of the liver that can lead to chronic liver disease, cirrhosis, liver cancer, liver failure, and even death. The disease is transmitted by blood and/or body fluids, and many people will have no symptoms when they develop the disease. The primary risk factors for hepatitis B are sexual activity and injection drug use. This disease is completely preventable with the Hepatitis B vaccine which is available to all age groups. A series of three (3) doses of vaccine are required for optimal protection. Missed doses may still be sought to complete the series if only one or two doses have been acquired. The HBV vaccine has a record of safety and is believed to confer lifelong immunity in most cases.

_____ I hereby certify that I have read this information about Hepatitis B (HBV) and **have elected not to receive the Hepatitis B vaccine.**

_____ I hereby certify that I read this information and **have received the initial dose of the Hepatitis B vaccine on ___/___/___.**

Meningococcal Disease is a rare but potentially fatal bacterial infection, expressed as either meningitis (infection of the membranes surrounding the brain and spinal cord) or meningococcemia (bacteria in the blood). Meningococcal disease strikes about 3,000 Americans each year and is responsible for about 300 deaths annually. The disease is spread by airborne transmission primarily by coughing. The disease can onset very quickly and without warning. Rapid intervention and treatment is required to avoid serious illness and/or death. There are five different subtypes (serogroups) of the bacterium that cause Meningococcal Meningitis**.** The current vaccine does not stimulate protective antibodies to Serogroups B, but it does protect against the most common strains of the disease including serogroups A, C, Y, and W-135. The duration of protection is approximately three to five years. The vaccination is very safe. Adverse reactions are mild and infrequent consisting primarily of redness at the injection site lasting up to two days. The Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) recommends that college freshman (particularly those who live in dormitories or residence halls) be informed about meningococcal disease and the benefits of vaccination and that those students who wish to reduce their risk for disease to be immunized. Any undergraduate students who wish to reduce their risk for disease may choose to be vaccinated.

_____ I hereby certify that I have read this information and **have elected not to receive the Meningococcal Meningitis vaccine.**

_____ I hereby certify that I have read this information and **have received the Meningococcal Meningitis vaccine on ____/____/____.**

Student Signature: _____ Date: _____

Return form to: **Emmanuel Christian Seminary at Milligan College**
P.O. Box 550
Milligan College, TN 37682

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Student Name: _____ **Birthdate**: _____

Section C: Proof of Immunization

NOTICE: To be completed and signed by the **Healthcare Provider**, or attach an official copy of your immunization records.

	Vaccine	Date (mm/dd/yy)	Date (mm/dd/yy)	Date (mm/dd/yy)	Total Doses	In lieu of vaccination . . . Serology Positive (mm/dd/yyyy)	Disease History (mm/yy)	Medical Exemption
Required	**MMR** (Born after 1956, 2 doses OR + serology)							
	Measles							
	Mumps							
	Rubella							
	Varicella (Born after 1979, 2 doses OR + serology OR history of chicken pox)							
	Meningococcal (MCV4) (1 Dose on or after 16th birthday if under age 22)							
Recommended	**Hepatitis B** (3 doses; **Required for students in health science prior to patient care.**)							
	Polio (Primary series)							
	Tetanus (DPT, DTap, DT, Tdap; with TD booster within 10 years)							

Tuberculosis SCREENING for International Students ONLY: Required to be done in the U.S. within the past 12 months. PPD placement, IGRA testing, x-ray, and appropriate treatment as deemed necessary by the Health Department or physician. A history of disease or BCG vaccination should not preclude testing of a member of a high risk group.

Screening Assessment (REQUIRED): ☐ Low Risk ☐ High Risk (additional testing applies)
PPD Test: Date Given: ____/____/____ Date Test Read: ____/____/____ Result: _____mm. ☐ Positive ☐ Negative
Chest X-ray (required for positive test): ☐ Positive ☐ Negative Date/duration of treatment: _____

Healthcare Provider Name:		Phone:	
Address:	City/State/Zip:		
Healthcare Provider Signature:		**Date:**	

Section D: Religious Exemption

NOTICE: Must be **notarized** if you decline required vaccinations due to religious beliefs and practices.

I understand that under Tennessee Law and/or Milligan College policy, newly enrolled traditional students are required to either be vaccinated against the below stated diseases or to obtain a medical or religious waiver from this law and/or policy. I have reviewed the CDC website information regarding the indicated immunizations at: http://www.cdc.gov/vaccines/pubs/vis/default.htm and understand the possible risks of not receiving immunizations include: becoming infected with the disease, death, transmitting vaccine-preventable disease to others, exclusion from school or house quarantine during an outbreak.

The following indicated immunization(s) is (are) prohibited by my religious beliefs and practices:

☐ Measles ☐ Mumps ☐ Rubella ☐ Varicella ☐ Meningococcal ☐ Hepatitis B series

_____ _____ _____ _____
Student Signature | Date | If under 18, Parent/Guardian Signature | Date

NOTARY PUBLIC: _____	**NOTARY SEAL:**
Date Commission Expires: _____	
Sworn and subscribed before this _____ day of _____, 20_____.	

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