UNION UNIVERSITY

IMMUNIZATION RECORD

HEALTH SERVICES

Parts A–C are required for all students. Part D is required for all students living on campus.

Name_____ Date of Birth _____ Phone # _____

Address _____ Email _____

A. MEASLES, MUMPS, AND RUBELLA (check one):

❒ Attach copy of Immunization record showing two (2) doses of Measles, Mumps & Rubella (MMR) vaccine

or

❒ Attach copy of immune MMR titer

The state of Tennessee requires all students, born after January 1, 1957, entering colleges and universities to provide proof of two (2) doses of Measles, Mumps, and Rubella (MMR) vaccine on or after the first birthday or proof of immunity to measles with an MMR titer (blood test).

B. VARICELLA OR "CHICKENPOX" (check one):

❒ Attach copy of Immunization record showing two (2) doses of varicella vaccine

or

❒ Attach copy of immune varicella titer

or

❒ Attach letter from *health care provider* stating that he/she believes student has had chickenpox. Year of illness: _____

The state of Tennessee requires all students born on or after January 1, 1980 to provide proof of two doses of varicella (chickenpox) vaccine given no earlier than 4 days before 1st birthday or proof of immunity to varicella with a varicella IgG (titer) blood test.

C. HEPATITIS B (HBV) IMMUNIZATION:

Recommended for all new students and required for students in the **School of Nursing**. 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. Hepatitis B vaccine is available to all age groups to prevent Hepatitis B viral infection. 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 have been acquired. The HBV vaccine has a record of safety and is believed to provide lifelong immunity in most cases. Union University Health Services, located on the Jackson Campus, is open Monday – Friday 8 a.m.-4p.m. and offers Hepatitis B vaccine for $65 per injection (price subject to change).

❒ I decline receipt of vaccine to protect against Hepatitis B.

or

❒ I have received the complete three dose series of the Hepatitis B vaccine (attach copy of record).

or

❒ I plan to receive the Hepatitis B series.

Student Must Sign Here _____ **Date**_____

D. MENINGITIS VACCINE:

New incoming students, who are less than 21 years of age, who will be residing in on-campus housing, must show proof of one meningitis vaccine and it must be either of the brand names, Menactra or Menveo (not Menomune). The Centers for Disease Control (CDC) recommends only one dose if given **after the age of 16**. Health Services will review each record to ensure adequate vaccination per CDC guidelines. If we find the student needs the vaccine, Union University's Health Services Clinic can provide it for $120. All students not living on campus are strongly encouraged to be vaccinated to reduce their risk of meningococcal disease.

❒ Attach copy of Immunization record showing dose of meningococcal vaccine (Menactra or Menveo) at 16 years of age or older.

❒ Living off campus.

I refuse immunization because of religious objections, have attached an official clergy statement, and affirm this reason under the penalties of perjury.

Signature _____ Date _____

Return to: Health Services, 1050 Union University Drive, Box 1806, Jackson, TN 38305
Contact information: 731-661-5284, Fax 731-661-5499, e-mail: swren@uu.edu

UNION UNIVERSITY

HEALTH FORM

HEALTH SERVICES

To be completed by all students.

Attach photo here

Full Name _____
First Middle Last

Gender ❒ M ❒ F Age _____ Birthdate _____

Home Address _____
Street City State Zip

Phone ( ) _____ Expected Date of Enrollment _____

Name of Parent, Guardian or Spouse (circle one) _____

Phone ( ) _____ Home Address _____
Street City State Zip

***Attach a copy of both sides of insurance ID card**

Current Medication(s): _____

_____

Current Health Problems and Past Health Problems including serious injuries, medical conditions and surgeries: _____

_____

_____

_____

_____

Allergies (Medications, Foods, Substances, etc.) _____

_____

_____

Student Treatment Consent

In case of serious illness or accident, I give Union University or its representative(s) permission to secure medical and/or surgical care to include transportation to a doctor or hospital of their choice, injections, examination, medication, and surgery that is considered necessary for my good health. I agree to pay all medical costs. In the event of a condition requiring minor care, I give my permission for treatment to the college physician or his staff.

All statements in this medical record are true to the best of my knowledge and belief. Should any change in my health status occur I understand that Student Health Services should be notified in writing.

_____ _____

Student's Signature Date Parent/Guardian's Signature (if student is under 18) Date

Consent for Release of Information

In order to provide continued and appropriate medical care, I give Union University or it representative(s) permission to release personal health information to health care professionals/medical facilities by E-mail, FAX, phone and mail.

_____ _____

Student's Signature Date