FREED-HARDEMAN UNIVERSITY *Student Health Form*

Please have your health care provider complete and sign this form or you may fill in your personal information and attach a copy of your vaccination records. Please mail or hand-deliver these forms prior to the first day of your first semester of classes to: FHU Office of Admissions, 158 E. Main St., Henderson, TN 38340.

The State of Tennessee requires immunizations for students attending private colleges and universities. They are listed below.

1. MEASLES, MUMPS AND RUBELLA: All students born on or after January 1, 1957, must provide proof of immunization with two doses of measles, mumps and rubella vaccine or serology showing immunity to measles, mumps, and rubella. Students may request a waiver if their physician indicates medical contraindications or for religious purposes.

2. VARICELLA "CHICKENPOX": All students born on or after January 1, 1980 must provide proof of immunization with two doses of varicella vaccine or serology showing immunity to varicella or documentation from a medical facility showing verification having been previously being diagnosed with the illness. Students may request a waiver if their physician indicates medical contraindications or for religious purposes.

IMPORTANT NOTICE: STUDENTS WHO ARE NOT IN COMPLIANCE WILL HAVE A "HOLD" PLACED ON THEIR ENROLLMENT UNTIL THEY HAVE MET THE IMMUNIZATION REQUIREMENTS OR HAVE INITIATED AND/OR CONTINUED THE IMMUNIZATION PROCESS FOR THE MULTI-INJECTION IMMUNIZATIONS.

PART I

Name _____
Last First Middle Preferred

Address (Street, Route, P.O. Box) _____

City _____ State _____ Zip _____ Country _____

Phone (with area code) _____ – _____ – _____ Cell Phone (with area code) _____ – _____ – _____

Semester of FHU Enrollment: ❑ Fall ❑ Spring ❑ Summer Year _____

Birth Date (MM-DD-YY) _____ – _____ – _____ Gender: ❑ Male ❑ Female

PART II *This part must be completed and signed by a health care provider. All information must be completed in English.*

1. M.M.R. (Measles, Mumps, Rubella): Two doses of Measles, Mumps and Rubella Vaccine were administered on or after the first birthday and on the following dates:
   Dose 1 _____/_____ (MO YR) Dose 2 _____/_____ (MO YR)

2. Varicella (Chickenpox): Two doses of vaccine were administered after the first birthday and 28 days apart.
   Dates of vaccination: Dose 1 _____/_____ (MO YR) Dose 2 _____/_____ (MO YR)

   OR: Varicella antibody was tested on this date with the following results:
   Date _____/_____ (MO YR) Reactive _____ Non-Reactive ____ Had Disease _____/_____ (MO YR)

Recommended, but not required:

Tetanus-Diphtheria (date of most recent immunization): Month _____ Year _____

Tuberculosis recommended within last 6 months: Month _____ Year _____

Polio primary series of immunization completed? ❑ Yes ❑ No Date: _____

Health Care Provider

Name *(please print)* _____

Address (Street, Route, P.O. Box) _____

City _____ State _____ Zip _____ Country _____

Phone (with area code) _____ – _____ – _____ FAX (with area code) _____ – _____ – _____

Signature _____