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: *Email admissions@cumberland.edu or fax 615-444-2569*