Certificate of Immunization

It is the student's responsibility to return this completed request to their local Bethel University Enrollment Counselor. For questions, please call Student Services at 877-880-1113.

This is required for face-to-face undergraduate students only.
Graduate and online applicants may disregard this form.

CERTIFICATE OF IMMUNIZATION

*The State of Tennessee requires students entering colleges, universities, and teechnical institutes with enrollment of greater than 200 students to provide proof of two (2) doses of Measles, Mumps, and Rubella (MMR) vaccine or proof of immunity to these diseases. If you were born before January 1, 1957, you're exempt from this requirement and should fill out Part I only. ~~All other persons must complete **either** Part II, Part III or Part IV.~~*

PART I: TO BE COMPLETED BY STUDENT

Name ____
Last *First* *Middle*

Social Security Number ____________________ **Date of Birth** ____________________

Applicant's Signature ______________________________ **Date** ______________

PART II: TO BE USED IF STUDENT HAS EXISTING VACCINATION RECORDS

Attach to this form any one:

1. Tennessee Certificate of Immunization (form 2414) or its equivalent from another state health department.
2. Official Immunization records from the military (attach a copy, not the original).
3. International Certificate of Vaccination (attach a copy, not the original).
4. Immunization records obtained from a public school record.

Attach any of these certificates. If you do not have any of these forms, continue on to the other side to complete either Part III or Part IV.

CERTIFICATE OF IMMUNIZATION

PART III: TO BE COMPLETED AND SIGNED BY PHYSICIAN OR AUTHORIZED HEALTH DEPARTMENT IF NEW IMMUNIZATIONS ARE OBTAINED

Check appropriate:	**Dates:**
________ Immunized with MMR	#1 ___/___/_____ #2 ___/___/_____
OR	
________ Immunized with 2 doses of individual vaccines	Measles #1 ___/___/_____ #2 ___/___/_____
	Mumps #1 ___/___/_____ #2 ___/___/_____
	Rubella #1 ___/___/_____ #2 ___/___/_____

________ Had blood test which confirms immunity to measles, mumps, and rubella. (Must attach a copy of laboratory report).

________ Medically contraindicated (i.e., allergic to vaccine, pregnancy, etc.) Must attach a statement from your physician (medical doctor or doctor of osteopathy only) as to the reason for and expected duration of the exemption.

Health Care Provider (Physician or Health Department)

Name ____
please print or stamp

Address ____

Signature ______________________________ **Phone** ____________________

PART IV: TO BE COMPLETED ONLY IF APPLICABLE

I refuse immunization because of religious beliefs; I have attached a statement to this effect, and affirm this reason under the penalties of perjury.

Signature ____ Date ________________