***IMMUNIZATION COMPLIANCE FORM***

*Louisiana R.S. 17:170 School of Higher Learning*

Student Health Services 504-816-4532 studenthealth@dillard.edu

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

 *(Last) (First) (M.I.)*

Student ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Semester of Enrollment: (please select) Fall  Spring  Summer 

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**This section must be completed and signed by a Physician or Health Care Provider**

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| **REQUIRED IMMUNIZATIONS**  |  |
| **MMR** (Measles, Mumps, Rubella) Two doses required  **OR** Positive antibody titers for measles, mumps, and rubella.  |  Dose #1 Date \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ Dose #2 Date \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ Serologic Test: Date \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_  **Result** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **Tetanus-Diphtheria**  **Tdap** \*\*The Last dose must be *within the past 10 years* of the start date.  |  Vaccine Date: \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_   |
| **Meningococcal** **\*\*** Must have *2 doses* or *1 dose* within the last 4 years of registration date. |  Dose #1 Date \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_  Dose #2 Date \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_  **Must Select Type**:  Menactra or  Menveo  |
| **Meningococcal B**Bexsero (two doses)Trumenba (three does) | Dose #1 Date \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_  Dose #2 Date \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ Dose #3 Date \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_ **Must Select Type**:  Bexsero or  Trumenba |
| **TB Skin Test** **\*\*** Last dose *within 6 months* of Registration  |  Vaccine Date: \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_  **Result:**  |
| **COVID-19 (Pfizer or Moderna) – Two doses required** **Manufacturer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  |  Dose #1 Date \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_  Dose #2 Date \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_  |
| **COVID-19 (Johnson & Johnson) – One dose required**  | Dose #1 Date \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_  |
| **COVID-19 Booster** **Manufacturer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **\*\*** Required if it has been 5 months since your last COVID-19 vaccination dose.  |  Dose #1 Date \_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_  Dose #2 Date \_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ **(Optional)**  |

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|  CLINIC STAMP  |

***HEALTH CARE PROVIDER*:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Print Name Signature*

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*Address*

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*Phone Date*

Rev. 11/10/23