***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