

PROOF OF IMMUNIZATION COMPLIANCE

Louisiana R.S. 17:170/Schools of Higher Learning

Please return the completed form to: University of Louisiana at Lafayette; Student Health Service:
PO Box 43692, Lafayette, LA 70504-3692, Fax: 337-482-1873

Name: _____ Date of Birth: _____ CLID/SSN: _____
(Last/Family) (First/Given)

When do you plan to start at UL Lafayette: _____ Month _____ Year

Email: _____ Telephone: _____

Instructions: Immunization requirements are applicable **ONLY** to students born on or after January 1, 1957. Sections A (and/or B) & C must be completed. You must either have a physician or health care provider complete Section A or submit the Universal Certificate of Immunizations provided by the Department of Health and Hospitals, Office of Public Health. **No other attachments or photocopies accepted.** If you have not been immunized for all required diseases, you may request an exemption by completing Section B. However, Section C cannot be waived and must be completed.
****IMPORTANT**:** Failure to complete **AND** turn in this form will **PREVENT** you from being able to schedule classes.

Section A: Documentation of Immunizations

1. MMR (M _____ **OR** _____)
Date of 2nd dose: _____

MEASLES
(Two Doses Required)
Date of 1st dose: _____
Date of 2nd dose: _____

AND
2. TETANUS
(One Dose Required Within 10 years)
Date: _____
Vaccine type: _____

MUMPS
(At least One Dose Required)
Date: _____

AND
3. MENINGITIS
(Two Doses of meningococcal vaccine)
Date: _____
Vaccine type: _____
(Minimum interval is eight weeks)
Date: _____
Vaccine type: _____

RUBELLA
(At least One Dose Required)
Date: _____

I have chosen not to be vaccinated for and am requesting an exemption from the following
Immunizations, and I am aware of the risks.

Vaccination(s) for which I am requesting exemption: _____

Reason for Immunization Exemption Request (please check one):

Medical _____ Personal _____ Shortage (unable to locate vaccine) _____ Other: _____
I understand that if I claim an exemption for personal or medical reasons, I may be excluded from campus and from classes in the event of an outbreak of measles, mumps, rubella, or meningitis until the outbreak is over or until I submit proof of immunization. I have reviewed information regarding vaccine-preventable diseases and related vaccinations contained on the website for the Center for Disease Control and Prevention (CDC): <http://www.cdc.gov/vaccines/hcp/vis/index.html>. If I am not 18 years of age or older, my parent or legal guardian must also sign below.

Student Signature Date Parent Signature (for students under 18 years old) Date

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Country of Origin: _____ (Do NOT leave blank)

Section C: Tuberculosis (TB) Screening and Targeted Testing

Instructions: Complete all questions in Section C, Part I.

- If the answer is **NO** to **ALL** questions, no further testing or action is required.
- If the answer is **YES** to any of the below questions, you are required to have your physician or health care provider complete Section C, Part II. You are required to have a tuberculin skin test (PPD). You may use record of a previous PPD skin test if it was within the last 12 months. PPD skin tests can be obtained from your physician or walk-in clinic.

****IMPORTANT**** YES by your physician or health care provider. ONL. esting
