



PROOF OF IMMUNIZATION COMPLIANCE

Vaccine Requirements are applicable only to students born on or after January 1, 1957
(Louisiana R.S. 17:170 Schools of Higher Learning)

Applicant's Name (Last, First, Middle)

Social Security Number

Date of Birth (Month/Day/Year)

Age Exempt (Born on or before December 31, 1956)

OPTION 1 – Immunization Verification – PHYSICIAN'S STATEMENT:

The above-named individual has been immunized as follows:

MMR 1: _____ MMR 2: _____ Tetanus-Diphtheria: _____
Date Date Date

Signature of Physician or Other Health Care Provider

Date (Above space for Physician's Address and/or Stamp)

OPTION 2 – SUBMISSION OF IMMUNIZATION RECORD (BY STUDENT)

I hereby submit my immunization record as proof of immunization against measles, rubella, mumps, and tetanus-diphtheria.

Signature of **Student**

Date

Signature of **Parent/Legal Guardian (If student is under age 18)**

Date

OPTION 3 – REQUEST FOR EXEMPTION

I understand that I may be excluded from campus and from classes in the event of an outbreak of any of the above-listed diseases until the outbreak is over or until I submit proof of immunization. (Please mark one of the following choices and provide details.)

MEDICAL REASON – Physician's statement _____

Signature of **Physician**

Date

PERSONAL REASON - _____

Signature of **Student** (and parent/guardian if student is under age of 18)

Date