DILLARD UNIVERSITY

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

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
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)**

***HEALTH CARE PROVIDER*:**

_____ _____
Print Name *Signature*

_____
Address

_____ _____
Phone *Date*

CLINIC STAMP

Rev. 05/27/22