



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.)

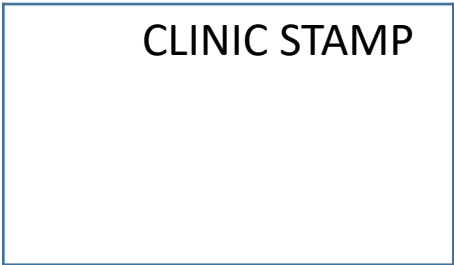
Student ID#: _____ Semester of Enrollment: (please select) Fall Spring Summer

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 <u>within the past 10 years</u> of the start date.	Vaccine Date: ____/____/_____
Meningococcal ** Must have <u>2 doses</u> or <u>1 dose</u> within the last 4 years of registration date.	Dose #1 Date ____/____/_____ Dose #2 Date ____/____/_____ Must Select Type: <input type="checkbox"/> Menactra or <input type="checkbox"/> Menveo
Meningococcal B Bexsero (two doses) Trumenba (three doses)	Dose #1 Date ____/____/_____ Dose #2 Date ____/____/_____ Dose #3 Date ____/____/_____ Must Select Type: <input type="checkbox"/> Bexsero or <input type="checkbox"/> Trumenba
TB Skin Test ** Last dose <u>within 6 months</u> 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 (Optional) Date ____ / ____ / ____



HEALTH CARE PROVIDER:

Print Name

Signature

Address

Phone

Date