DILLARD UNIVERSITY

Student Health Services
Proof of Immunization Compliance Form
(LOUISIANA R.S. 17:170 SCHOOL OF HIGHER LEARNING)

STUDENT MUST COMPLETE

Name_____

Please Print (Last Name) (First Name) (Middle Initial)

Student ID Number _____ Semester of Enrollment _____ Year _____

Date of Birth: Month_____ Day_____ Year_____

PHYSICIAN COMPLETES

PHYSICIAN OR OTHER HEALTH CARE PROVIDER VERIFICATION

Measles (Rubeola)	**Rubella**	**Mumps**	**Tetanus-Diphtheria**
1st Immunization: _____ Date and 2nd Immunization: _____ Date Date of Disease: _____ Date Serologic Test: _____ Date & Result	Immunization:_____ Date Serologic Test:_____ Date Result: _____ Date **TB Skin Test** Immunization: _____ Date (within 6 months of registration) Result:_____ Date	Immunization : _____ Date Date of Disease: _____ Date Serologic Test:_____ Date & Result	Immunization : _____ Date (within 10 years) **Meningococcal** 1st Immunization: _____ Date and 2nd Immunization: _____ Date

PHYSICIAN COMPLETES

(Please place address or stamp below)

_____
Physician Signature or other Health Care provider

_____
Date

REQUEST FOR EXEMPTION:

If you request an Exemption for medical reasons, please check the appropriate blank and provide the information requested.

☐ Medical Reasons: (Physician's statement required - use space below)

_____
_____
_____
_____

I understand that if I claim for medical reasons, I may be excluded from campus and from classes in the event of an outbreak of measles, mumps, rubella, diphtheria or meningitis until the outbreak is over or until I submit proof of immunization. If I am not 18 years of age, my parent or legal guardian must sign below.

_____ _____ _____ _____

(Student's Signature) (Date) (Parent or Guardian, if required) (Date)