Student Immunization Compliance Form

Return to:3050 Dr Martin Luther King Dr, Shreveport, LA 71107

STUDENT COMPLETES

Name: ____ Date of Birth: Month_____Date_____Year_____

SS Number: ______________ — __________ — ______________ Phone #: ________________________________

Gender: Male Female Email: ______________________________

Enrollment Status: New Freshman Transfer Readmit Visiting International

Permanent Address: ____

City: ____ State: ______________ Zip Code: ____________

PHYSICIAN OR HEALTH DEPARTMENT COMPLETES

Measles, Mumps, Rubella (MMR): #1 Month: _________ Day: _________ Year: _________

#2 Month: _________ Day: _________ Year: _________

Tetanus-Diphtheria-Pertussis (Required within 10 years):

Tdap Month: _________ Day: _________ Year: _________

Td Month: _________ Day: _________ Year: _________

Meningococcal (Required within 5 years):

Menactra Month: _________ Day: _________ Year: _________

or **MENVEO** Month: _________ Day: _________ Year: _________

HEALTH CARE PROVIDER

Name: ______________________________________ Date: _______________

Signature: ____

Telephone (Area Code and Number): ____________________________________

Clinic stamp here:

REQUEST FOR EXEMPTION FROM IMMUNIZATION

If you request an exemption for medical or personal reasons, please check the appropriate box and provide the information requested.

☐ Medical Reasons ☐ Personal/Religious Reasons

State Reasons:

____

I understand that if I claim exception I may be excluded from campus and from classes in the event of an outbreak of disease until the outbreak is over or I submit proof of immunization. If I am not 18 years of age, my legal guardian must sign below.

Student's Signature: __________________________________ Parent/Guardian: __________________________________

PLEASE MAKE A COPY OF THIS DOCUMENT FOR YOUR PERSONAL RECORDS
YOU WILL NOT BE PERMITTED TO REGISTER UNTIL YOU COMPLETE THIS FORM