OUR LADY OF THE LAKE COLLEGE
Franciscan Missionaries of Our Lady Health System

PROOF OF IMMUNIZATION COMPLIANCE

(Louisiana R.S. 17:170 Schools of Higher Learning)

Vaccine Requirements Are Applicable Only To Students Born On Or After January 1,1957

(PLEASE PRINT)

Name: _____
(Last) (First) (M)

SS#: _____

Date of Birth: Month _____ Day _____ Year _____

Physician or Other Health Care Provider Verification:

Measles (Rubeola)	Rubella	Mumps	Tetanus-Diphtheria
1 st Immunization: _____ (Date) and 2 nd Immunization:_____ (Date) or Date of Disease: _____ (Date) or Serologic Test: _____ (Date & Result)	Immunization: _____ (Date) or Serologic Test: _____ (Date) and Result: _____	Immunization:_____ (Date) or Date of Disease:_____ (Date) or Serologic Test:_____ (Date&Result)	Immunization:_____ (Date within 10 years)

_____ Date:_____
(Signature of Physician or Other Health Care Provider)

REQUEST FOR EXEMPTION:

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

1. **Medical reasons: _____ (Physician's statement – use space below)**
2. **Personal reasons: _____ (State reason in space provided)**

_____

I understand that if I claim exemption for personal or medical reasons, I may be excluded from campus and from classes in the event of an outbreak of measles, mumps, or rubella 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)

THIS FORM IS A REQUIRED DOCUMENT AND MUST BE COMPLETED AND RETURNED WITH YOUR APPLICATION
REMEMBER! YOU WILL NOT BE ADMITTED NOR PERMITTED TO ENROLL UNTIL THIS COMPLETED FORM IS RETURNED
IMPORTANT: Make a copy of this form for your personal record