## Please return the completed form to: University of Louisiana at Lafayette; Student Health Service: PO Box 43692, Lafayette, LA 70504-3692, Fax: 337-482-1873

Name: Date of Birth: CLID/SSN:	
Telephone: Instructions: Immunization requirements are applicable  to students born on or after January 1, 1957. Sections A (and/or B) & C must be comple  Date of 1st dose: Date of 2nd dose:  Date:  Date:  Date:  Phylhave chosen not to b vaccinated for and am re-	
to students born on or after January 1, 1957. Sections A (and/or B) & C must be comple    Date of 1st dose:   Date of 2nd dose:   Date:   Date:   Date:   Date:   Phylhave chosen not to b vaccinated 6r and am re-	
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Medical Personal Shortage (unable to locate vaccine) Other:	-t -
derstand that if I claim an exemption for personal or medical reasons, I may be excluded from campus and from classes in the event reak of measles, mumps, rubella, or meningitis until the outbreak is over or until I submit proof of immunization. I have reviewed inforr	nation
rding vaccine-preventable diseases and related vaccinations contained on the website for the Center for Disease Control and Prevention (//www.cdc.gov/vaccines/hcp/vis/index.html. If I am not 18 years of age or older, my parent or legal guardian must also sign below.	CDC):
Student Signature Date Parent Signature Date (for students under 18 years old)	

## Louisiana R.S. 17:170/Schools of Higher Learning

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Name:			_ Date of Birth:	CLID/SSN:
_	(Last/Family)	(First/Given)	_	
Country o	of Origin:			
• If • If Yo	the answer is to any of the below of	further testing or action is requi questions, you are required to h n test (PPD). You may use record	nave your physician or healt	th care provider complete Section C, Part II. est if it was within the last 12 months. PPD skin
	YESbyom your physicn or h	nealth care prlinic. ONL. esting		
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