OUR LADY OF HOLY CROSS COLLEGE

Certificate of Immunization

To be completed by student:

Name:_____
Last First M.I. Maiden
Address:_____
Street City State Zip
Phone #:_____ Date of Birth:_____ Student ID #:_____

Date of first attendance:_____ Today's Date:_____

To be completed by Healthcare Provider:

IMMUNIZATION POLICY

THE LOUISIANA LEGISLATURE HAS PASSED ACTS 1047, 251 AND 711 REQUIRING THAT STUDENTS BE IMMUNIZED AGAINST PREVENTABLE AND/OR COMMUNICABLE DISEASES, INCLUDING BUT NOT LIMITED TO: MEASLES, MUMPS, RUBELLA, TETANUS-DIPHTHERIA, AND MENINGITIS.

THEREFORE, OLHCC REQUIRES ALL STUDENTS TO PROVIDE PROOF OF IMMUNIZATION AGAINST THE LISTED DISEASES. IF YOU WERE BORN AFTER JANUARY 1, 1957, WE NEED PROOF OF TWO LIVE MEASLES VACCINES. IF YOU WERE BORN PRE-1957, YOU MUST SUBMIT PROOF OF A TETANUS-DIPHTHERIA THAT HAS BEEN ADMINISTERED WITH THE PAST 10 YEARS, AS WELL AS PROOF OF MENINGOCOCCAL VACCINATION. YOU MUST HAVE YOUR PHYSICIAN OR HEALTH CARE PROVIDER COMPLETE AND RETURN THIS FORM.

MEASLES / MMR VACCINE #1:_____ RUBELLA VACCINE:_____

MEASLES / MMR VACCINE#2:_____ MUMPS VACCINE:_____

TETANUS-DIPHTHERIA:_____ Td BOOSTER:_____
(MUST be dated within the past 10 YEARS)

MENINGOCOCCAL VACCINE (MCV4) :_____

_____
Health Care Provider's Signature Date

_____ _____
Name of Healthcare Provider Address of Healthcare Provider
_____

REQUEST TO WAIVE VACCINES: MEDICAL: **Must attach a physician's statement.**
(please circle that which applies) PERSONAL: **Must state reason below.**
RELIGIOUS:

Waiver Statement for students declining the Meningococcal Vaccine –

I have been fully informed by reading the Centers for Disease Control and Prevention's ***Meningococcal Vaccines – What You Need to Know*** Vaccine information statement and understand that my health could be negatively affected and my life possibly endangered by not receiving the Meningococcal vaccine. I hereby assume full responsibility for any and all possible present and future results or complications of my condition as a result of not receiving the vaccination. By signing this document, I declare myself to be mentally competent and do now and forever release Our Lady of Holy Cross College and the Department of Health and Hospitals and all its agents, attending health care professionals, and other personnel from any and all legal or financial responsibility as a result of not receiving the vaccination. I certify that I have read and fully understand this Waiver of Vaccination and Release from Responsibility. All explanations were made to me prior to signing my name. I have elected not to receive the vaccination of my own free will.

Statement to be signed by all students requesting to waive vaccinations (including Meningococcal) -

I understand that if I request to waive any of the above listed vaccinations for any reason, I may be excluded from campus and from classes in the event of an outbreak of the above listed diseases until the outbreak is over or until I have submitted proof of vaccination. (Must have parent or guardian's signature for students under 18 years of age.)

_____ _____ _____ _____
Student's Signature Date Parent/Guardian's signature Date