

PROOF OF IMMUNIZATION COMPLIANCE

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

For Applicant:

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Applicant Email: _____

Degree Applying for w/ Return Instructions:

Leavell College Graduate Program Doctoral Program

Leavell College Admissions
3939 Gentilly Blvd
New Orleans, LA 70126
leavelladmissions@nobts.edu

NOBTS Admissions
3939 Gentilly Blvd
New Orleans, LA 70126
gradadmissions@nobts.edu

NOBTS ProDoc Admissions
3939 Gentilly Blvd
New Orleans, LA 70126
dmin@nobts.edu

NOBTS ReDoc Admissions
3939 Gentilly Blvd
New Orleans, LA 70126
phd@nobts.edu

Instructions: Complete the Proof of Immunization Compliance in three ways.

1 One, take this document to a physician and have them complete it.

2 Two, retrieve a copy of your immunizations which will suffice of completion.

3 Three, complete the exemption section and LDH form.

PLEASE RETURN TO ADMISSIONS OFFICE BY UPLOADING TO YOUR APPLICATION PORTAL OR EMAILING A COPY TO LISTED EMAILS ABOVE.

Measles (Rubeola)

The state of Louisiana requires proof of two measles vaccinations for students enrolling at Louisiana institutions of higher learning born after 01/1957.

Date of 1st Measles: _____

Date of 2nd Measles: _____

Date of Serologic Proof of Immunity: _____

*Must attach lab results of serologic proof

Tetanus-Diphtheria

Required within the past ten years.

Date of Immunization: _____

Please check: TD TDAP

Mumps and Rubella

The state of Louisiana requires proof of one vaccination against mumps and rubella for all new students enrolling at Louisiana institutions of higher learning born after 1/1/57.

Mumps

Date of Immunization: _____

Date of Serologic Proof of Immunity: _____

Rubella (German measles)

Date of Immunization: _____

Date of Serologic Proof of Immunity: _____

*Must attach lab results of serologic proof

Meningitis:

The state of Louisiana requires proof of Meningococcal immunization for college freshman.

Last Dose: _____

Vaccine Type: _____

Place Clinic Stamp Below

Name of Health Care Provider: _____ Address: _____

Signature of Health Care Provider: _____ Date: _____

REQUEST FOR EXEMPTION FROM IMMUNIZATION

Please copy and paste this in a web browser, print and fill out form and upload to your application portal or send to your admissions counselor. *Please put N/A for guardian if signing for yourself.

<https://ldh.la.gov/assets/oph/Center-PHCH/Center-PH/immunizations/statement-of-exemption-from-immunizations.pdf>

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CONTACT@NOBTS.EDU | 504-282-4455