

McNeese State University
Proof of Immunization Compliance

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Entered

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Received

NOTE: All students who are attending McNeese for the first time must complete and return this form (Louisiana R.S. 17:170 and R.S. 17:170.1 Schools of Higher Learning.) Do not send original immunization records.

Copies of records that have been validated are acceptable. Your high school, private physician, or local public health clinic may be able to assist you in locating your immunization records. McNeese State University requests that students do not send their original immunization records. The University cannot be responsible for maintaining permanent immunization records.

Instructions

1. Complete the student section.
2. Have your physician or health care provider complete the immunizations section or attach a copy of your immunization records.
3. In the event that records cannot be provided for the measles, mumps, rubella, diphtheria, tetanus immunization requirement, coronavirus (COVID-19) vaccination requirement, and/or the meningitis vaccination requirement, complete the waiver section on the back of the form.

Student Information

MSU ID or Social Security Number	Last Name	First	Middle	Other/Maiden	
Birthdate (mm/dd/yyyy)	Area Code/Phone		Email Address		
Indicate semester and year that you are applying for admission: <input type="checkbox"/> Fall (August) _____ (yyyy) <input type="checkbox"/> Spring (January) _____ (yyyy) <input type="checkbox"/> Summer (June/July) _____ (yyyy)					
Address (Number, Street, Apt #)		City	Parish/County	State	Zip

Immunizations - Physician or Other Health Care Provider Verification

Dates of Immunization:

DTP/Td						
1st	2nd	3rd	B	B	B	B
MMR						
1st			2nd			
Measles (Rubeola)						
Date of Disease:				Serologic Test:		
Mumps						
Date of Disease:				Serologic Test:		
Rubella						
Date of Disease:				Serologic Test:		
Meningococcal (Meningitis)						
Menomune (MPSV4): Date of Immunization:				Menactra (MCV4): Date of Immunization:		
Coronavirus (COVID-19)						
1st	2nd	B				

Certifying Official

Name: _____

Address: _____

Area Code / Phone: _____

X _____
 (Signature of Physician or Health Care Provider)

Waiver of Vaccination and Release from Responsibility *If under 18, parent/guardian must also sign.

(Print) Full Name _____ McNeese Banner ID # _____ Date _____

Waiver of Vaccination (Measles, Mumps, Rubella, Diphtheria, Tetanus, COVID-19)

I request an exemption from the immunization requirement for one or more of the listed diseases (measles, mumps, rubella, diphtheria, tetanus, COVID-19). The reason for my requesting the waiver is (check one):

Personal Medical Religious State reason: _____

I understand that I may be required to leave campus and be excluded from classes in the event of an outbreak of any of the listed diseases until the outbreak is over or until I submit proof of immunization.

Signature of Student _____ Date _____ Signature of Parent / Guardian (if required) _____ Date _____

Waiver of Vaccination (Meningitis)

BE IT KNOWN that on this date I have read and been fully informed by the Centers for Disease Control and Prevention's Vaccine Information Statement: Meningococcal Vaccines—What You Need to Know, available at www.cdc.gov. I understand that my health could be negatively affected and my life possibly endangered by not receiving the vaccine. The reason for my completing this waiver is (check one):

Personal Medical Religious State reason: _____

I declare myself to be a person of the full age of majority and to be mentally competent. I hereby assume full responsibility for any and all possible present or future results or complications of my condition as a result of not receiving the vaccination.

I do further hereby now and forever free and release the University 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 (or have had read to me) and fully understand this Waiver of Vaccination and Release from Responsibility. All explanations were made to me and all blanks completed before signing my name. I have elected, of my own free will, not to receive the vaccination.

I understand that I may be required to leave campus and be excluded from classes in the event of an outbreak of any of the listed diseases until the outbreak is over or until I submit proof of immunization.

Signature of Student _____ Date _____ Signature of Parent / Guardian (if required) _____ Date _____