UNIVERSITY OF HOLY CROSS

4123 Woodland Drive
New Orleans, LA 70131

Immunization Wavier

(Louisiana R.S. 17:170 SCHOOL OF HIGHER LEARNING)

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: _____

IMMUNIZATION POLICY

THE UNIVERSITY OF HOLY CROSS REQUIRES ALL STUDENTS TO PROVIDE PROOF OF IMMUNIZATION AGAINST THE LISTED DISEASES. IF YOU WERE BORN ON OR AFTER JANURARY 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 WITHIN THE PAST 10 YEARS, AS WELL AS PROOF OF TWO MENINGOCOCCAL VACCINATIONS SEPERATED BY AT LEAST 8 WEEKS.

MEASLES/MMR VACCINE #1: _____

MEASLES/MMR VACCINE #2: _____

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

MENINGITIS VACCINE #1: _____
(Minimum interval is eight weeks – after 16th Birthday)

RUBELLA VACCINE: _____

MUMPS VACCINE: _____

Td BOOSTER: _____

MENINGITIS VACCINE #2: _____

REQUEST TO WAIVE VACCINES:

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 University of Holy Cross 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.

PLEASE SEE REVERSE SIDE FOR MORE INFORMATION

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 student's under 18 years of age.)

(Please circle that which applies) MEDICAL PERSONAL RELIGIOUS

_____

_____

_____

_____ _____

Student's Signature Date

_____ _____

Parent/Guardian's Signature Date