

NEW ORLEANS BAPTIST THEOLOGICAL SEMINARY  
DIVISION OF CHURCH MUSIC MINISTRIES

**Proof of Immunization**

NAME \_\_\_\_\_ NOBTS-ID \_\_\_\_\_  
(Last) (First) (MI)

DATE OF BIRTH (MM/DD/YY) \_\_\_\_\_

**PHYSICIAN OR OTHER HEALTH CARE PROVIDER VERIFICATION**

(Provide date for either immunization or serologic proof of immunization. **ALL** items are required.)

<p><b>Measles (Rubeola)</b> (The state of Louisiana requires proof of <b>two</b> vaccinations against measles since 1968 for all new students born after 1/1/57.)</p> <p>Date of 1st immunization: _____</p> <p>Date of 2nd immunization: _____</p> <p>*Date of Serologic Proof of Immunity: _____</p>	<p>(The state of Louisiana requires proof of <b>one</b> vaccination against mumps and rubella for all new students enrolling at Louisiana Institutions of Higher Learning, born after 1/1/57.)</p> <p><b>Mumps</b></p> <p>Date of immunization: _____</p> <p>*Date of Serologic Proof of Immunity: _____</p> <p><b>Rubella (German measles)</b></p> <p>Date of immunization: _____</p> <p>*Date of Serologic Proof of Immunity: _____</p>	<p><b>Tuberculosis</b> (NOBTS requires test <b>within the last year.</b>)</p> <p>Date of screening: _____</p> <p>Please check (mantoux) ppd _____ tine _____</p> <p>Result _____</p> <p>Date of treatment for positive test or TB (if treated, please give details.) _____</p> <p>_____</p> <p>_____</p> <p>*Date of Serologic Proof of Immunity: _____</p>
<p><b>Diphtheria-Tetanus</b> (every 10 years)</p> <p>Date of immunization: _____</p>		

\*Must provide documentation of lab results.

PHYSICIAN/HEALTH CARE PROVIDER (Please print.) \_\_\_\_\_

ADDRESS \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

There will be a charge for any shots given by NOBTS clinic. If you should have any questions regarding the amount of the shots or any other questions concerning immunization, please call the clinic at 504-816-8596.

**REQUEST FOR MEDICAL EXEMPTION FROM IMMUNIZATION**

If you request exemption for medical reasons, you must have your physician provide the medical explanation for the request in the space below.

IMMUNIZATION(S) \_\_\_\_\_ EXPLANATION: \_\_\_\_\_

PHYSICIAN'S SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_

I understand that if I claim medical exemption, I may be excluded from campus and from classes in the event of an outbreak of measles, mumps, or rubella until the outbreak is over or until I submit proof of immunization.

STUDENT'S SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_

**Return completed Proof of Immunization to:**

New Orleans Baptist Theological Seminary  
Division of Church Music Ministries  
3939 Gentilly Blvd., New Orleans, LA 70126