John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health
Office of Public Health

REPORT OF YELLOW FEVER VACCINATION CENTERS

NAME OF CENTER___________________________ STAMP NO.___________

ADDRESS______________________________ TELEPHONE NO.____________

Clinic days and hours yellow fever vaccinations are offered:

Days: __________________________ Hours:_______________________

Report Period (6 months): (__________) through (__________)

No. of yellow fever vaccinations administered: ______________________________

Did you receive information subsequently, directly or indirectly, to indicate if any of the persons vaccinated developed a complication of vaccination with these vaccines? (Please check one): ( ) YES ( ) NO

If YES, please provide details on a separate sheet including name of vaccinee, address, vaccine used, manufacturer, lot number, date of vaccination and nature of complication.

Date of report: _____________ Medical Director: _____________________
(Please print name)

Signature: ______________________

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