



State of Louisiana

Department of Health and Hospitals
Yellow Fever Vaccination Center Certification Program

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) ending date: _____

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: _____