PROOF OF IMMUNIZATION COMPLIANCE

Louisiana R.S. 17:170/Schools of Higher Learning

Please Print

Name:_____ Semester of Enrollment:_____
(Last) (First) (M.I.)

Address:_____ Email:_____
(Street/P.O. Box) (City) (State) (Zip Code)

Da te of Birth:_____ LSU ID Number: 89- _ _ _ - _ _ _ _ Telephone: (____)_____

IMMUNIZATION REQUIREMENTS FOR LSU STUDENTS

THIS MUST BE COMPLETED BY A PHYSICIAN OR HEALTH CARE PROVIDER - **NO ATTACHMENTS ACCEPTED**

REQUIREMENTS:

MMR (Measles, Mumps, Rubella)
(Two Doses Required)
Date of 1st dose:_____
Date of 2nd dose:_____

or

MEASLES
(Two Doses Required)
Date of 1st dose:_____
Date of 2nd dose:_____

MUMPS
(At least One Dose Required)
Date: _____

AND

RUBELLA
(At least One Dose Required)
Date:_____

TETANUS-DIPHTHERIA (Td or Tdap)
(One Dose Required Within 10 years)
Date:_____
Vaccine type: _____

AND

MENINGITIS (ACYW-135)
(One Dose of Menactra or Menveo Anytime or a Dose of Menomune *Within the Past Year*)
Date: _____
Vaccine type: _____

_____ _____
Signature of Health Care Provider *Date*

_____ (_____) _____
Address *Telephone*

Request for Immunization Exemption: If you request an immunization exemption for medical or personal reasons or due to an inability to locate a specific vaccine, please check the appropriate box and provide the requested information.

□ Medical (physician's statement required) □ Personal (state reason in space below) □ Shortage (unable to locate vaccine)

I have received and reviewed information from the Center for Disease Control and Prevention's (CDC's) website at http://www.cdc.gov/nip/publications/VIS/default.htm regarding vaccine preventable diseases and related vaccinations and have chosen not to be vaccinated. I understand that if I claim exemption for personal or medical reasons, I may be excluded from 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. If I am not 18 years of age, my parent or legal guardian must sign below.

_____ _____ _____ _____
Student's Signature *Date* *Parent or Legal Guardian, if required* *Date*

Name: _____ ID Number: 89 - _ _ _ - _ _ _ _

TUBERCULOSIS QUESTIONNAIRE

(MANDATORY – NO EXEMPTIONS)

The Student Health Center is evaluating all entering students for exposure to tuberculosis (TB). Please review and complete the information below **even if you have received a BCG (TB) vaccination in the past**. If you have any questions, please contact the Student Health Center at (225) 578-0593.

PAST HISTORY	**YES**	**NO**
1. Were you born in, have you ever lived in, or recently traveled to (within the past 5 years) any country in the following areas of the world? *Africa, Asia, Caribbean nations, Central America (excluding Mexico), Eastern Europe, India and other Indian Subcontinent Nations, Middle East, Portugal, South America, or South Pacific (excluding Australia and New Zealand).*	____	____
2. Do you have a history of cancer, leukemia, kidney disease, diabetes, alcoholism, or intravenous drug use?	____	____
3. Have you resided, worked or volunteered in a prison, homeless shelter, hospital, nursing home, or other long-term treatment facility?	____	____
4. Do you have AIDS/HIV or take immunosuppressive medication such as prednisone?	____	____
5. Have you been in close contact with someone with TB?	____	____

IMPORTANT: If you have answered "YES" to any of these questions, you are required to have a PPD skin test within the past year before you can pay University fees. You can obtain the PPD skin test from your physician or public health clinic.

NOTE TO HEALTH CARE PROVIDERS: Please record the size of the induration in millimeters. If there is no reaction, please record as "0 mm". **Students who have had a BCG vaccine are still required to have a PPD skin test**. If the screening skin test is positive (10mm or greater for those who answer "YES" to questions 1, 2, or 3, and 5mm or greater for those who answer "YES" to questions 4 or 5), we require the QuantiFERON-TB Gold (QFT) or T-Spot blood test to confirm the student has actually been exposed to TB in the past. (A chest x-ray is required, if the QFT test is also positive.) **PLEASE FOLLOW THE CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) GUIDELINES FOR THE TREATMENT OF LATENT TUBERCULOSIS INFECTION (LTBI) – SEE WWW.CDC.GOV.**

Date PPD Applied: _____ Date PPD Read: _____ Size of Induration: _____ mm

Date of QFT or T-Spot (circle type & **provide copy of result**): _____ Result: Negative_____ Positive_____

Date of Chest X-ray: _____ Result: Normal_____ Abnormal_____

Name of Medication: _____ Date Initiated: _____

Health Care Provider's Name, Address, tele #: _____

Health Care Provider's Signature: _____

****REMEMBER! You will not be eligible to pay University fees until all immunization records are in compliance or the exemption is signed.**

****RETURN THIS FORM TO:** *(in person, fax, mail, or e-mail)*

LSU Student Health Center
Immunizations
150-B Infirmary Road
Baton Rouge, LA 70803

Tel: (225) 578-0593
Fax: (225) 578-5282
Email: immunization@lsu.edu
Web: www.lsu.edu/shc

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