

STUDENT HEALTH SERVICES

478 S. JOHNSON ST – 3RD FLOOR
NEW ORLEANS, LOUISIANA 70112



Entering School of (select one):

Allied Health Dentistry Medicine Nursing Public Health (joint MD/MPH)

Program _____ Entrance Date (Month & Year) _____

**FULL AND PRECISE INFORMATION IS A REQUIREMENT FOR REGISTRATION.
EACH QUESTION MUST BE ANSWERED. INCOMPLETE RECORDS WILL RESULT IN A HEALTH BLOCK.**

PERSONAL INFORMATION - PLEASE PRINT OR TYPE ALL INFORMATION.

Name _____
Last First Middle or Maiden

Address _____ Telephone () _____ - _____

Date of Birth _____ Marital Status _____ Sex _____ Student ID#: _____

EMERGENCY CONTACT IN THE EVENT OF SERIOUS ACCIDENT OR ILLNESS:

Name _____ Relationship _____

Address _____ Telephone () _____ - _____

PRIMARY CARE PHYSICIAN

Name _____ Office Telephone () _____ - _____

Office Address _____

MEDICAL CONSENT ---IMPORTANT

In case of a medical emergency, call: University Physician Local personal physician

Local Physician's Name _____

Address _____ Office Telephone () _____ - _____

If the attempt to reach my personal physician is unsuccessful, I authorize the University Physician to prescribe such treatment as he/she reasonably judges to be in my best interest and authorize him/her and those he/she directs to administer that treatment.

Student's Signature _____ Date: _____

****PLEASE UPLOAD COMPLETED FORM TO: THE STUDENT HEALTH SUBMISSION PORTAL**

*Go to the LSU Health New Orleans website, <https://www.lsuohsc.edu>, Click on MENU → MyLSUHSC → Self Service → Academic Self-Service then you must login and continue to upload your completed form.

Last

First

Middle or Maiden

DOB

IMMUNIZATION HISTORY AND LAB WORK

All blood tests/titers are MANDATORY and this form must be completed for verification of dates and titers.

****Dates of immunizations must be specified and you MUST ATTACH documentation of all blood work and titers.****

If titers are negative, you must show proof of booster or repeated vaccine series (if required).

1. Varicella Titer Date _____ Titer results _____ Varivax #1 Date _____

Varivax #2 Date _____

2. Measles Titer Date _____ Titer results _____ MMR #1 Date _____

3. Mumps Titer Date _____ Titer results _____ MMR #2 Date _____

4. Rubella Titer Date _____ Titer results _____ MMR #3 Date _____

(If required)

5. Tetanus/Diphtheria with Pertussis (within last 10 years) Date _____

6. Hepatitis B vaccine dates 1st _____ 2nd _____

3rd _____ (If required) Repeat #1 _____ #2 _____

7. Hepatitis B Surface Antibody Titer (**QUANTITATIVE**) Date: _____ Result: _____ (**numerical value required**)

8. Tuberculin Skin Test (within 1 year) Date _____ Result _____ TB form attached (circle) Y or N

OR

T-Spot or Quantiferon Gold (within 1 year) Date _____ Result _____

*If the TB Test is known to be positive, a chest x-ray is required within the past 6 months + yearly symptoms review.

Date _____ Result _____

10. Meningitis Vaccine (within last 10 years) Date _____

11. Flu Vaccine Date _____ (**If entering during flu season; Annual flu or waiver due by Nov 1**)

12. COVID-19 Vaccine Manufacturer Name _____

#1 (Date) _____ #2 (Date) _____ Booster (Date) _____ Additional Doses (Date) _____

***For Refusal of Meningitis, Flu and COVID; a Refusal of Vaccination Form must be completed and uploaded!**

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STUDENT HEALTH SERVICES
478 S. JOHNSON ST. – 3RD FLOOR
NEW ORLEANS, LA 70112
OFFICE (504) 568-1800
FAX 504-568-1799

Annual TB Skin Test

Name: _____
Last First

DOB: _____

Program: AH DS GS MED NUR

Date Administered: _____

Test Site: _____

Administered by: _____

Patient instructed and agreed to return to clinic within 48-72 hours for reading of TB skin test _____
Initial here

For office use only

Result: NEG@_____mm POS@_____mm _____
Date Read & Time Name of Person

- CXR Neg Pos
- INH Student Health to manage INH
- Wetmore to manage INH
- TB sx discussed w/pt

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TUBERCULOSIS SCREENING

Annual form only required after positive PPD or bloodwork

(This form should be completed by your health care provider)

Name: _____ Date: _____

PPD Date: _____ PPD Result: _____ mm

Quantiferon Gold or T-Spot Date: _____ Result _____ mm

If PPD/Quantiferon Gold or T-Spot Positive:

1) Date of positive testing: _____

2) Treatment: _____ Dates: _____

3) Chest X-Ray: _____ Date: _____
Results within past 24 months

Screening Practitioner's Name (Print) _____

Date _____

Screening Practitioner's Signature _____

Are you currently experiencing any of the following symptoms?

	Yes	No
• Fever	<input type="checkbox"/>	<input type="checkbox"/>
• Cough	<input type="checkbox"/>	<input type="checkbox"/>
• Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
• Hemoptysis	<input type="checkbox"/>	<input type="checkbox"/>

Applicant's Signature

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