STUDENT HEALTH SERVICES
2020 GRAVIER STREET, 7th 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_____ Social Security No: _____-_____-_____

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:* _____

_____ _____

Last First Middle or Maiden DOB

IMMUNIZATION HISTORY AND LAB WORK

All blood tests/titers are MANDATORY and this form must be completed and signed by a physician or healthcare provider.

Dates of immunizations must be specified and you MUST ATTACH supporting documentation of all labs and titers.

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

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

   Varivax #2 Date _____

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

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

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

   Booster (if required)

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

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

   3rd _____ Booster_____ (if required)

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

8. Tuberculin Skin Test (within 1 year) Date _____ Result _____

   OR

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

*If the Tuberculin Skin 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) _____

*Meningitis and flu vaccination declination/waivers attached if necessary
*COVID exemption requests must be submitted via LSUHSC website on the Coronavirus page

HEALTH CARE PROVIDER CERTIFICATION:

Provider's name (please print) _____

Address _____ Telephone: ( ) _____

Provider's signature _____ Date: _____

PLEASE RETURN COMPLETED FORM TO: studenthealthstaff@lsuhsc.edu

Revised 7/1/22

LSU STUDENT HEALTH SERVICES
2020 GRAVIER ST., 7TH FLOOR
NEW ORLEANS, LA 70112
OFFICE (504) 525-4839
FAX 504-777-2922

Annual TB Skin Test

Name: _____
Last First

DOB: _____

Program: AH DS GS MED NUR

Date Administered: _____

Test Site: _____

Administered by: _____

Patient instructed and agrees 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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LSU Health NEW ORLEANS

TUBERCULOSIS SCREENING

Form only required after positive PPD or bloodwork

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

Name of applicant: _____ **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

Bottom half of form must be completed yearly after positive chest X-ray.

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Are you currently experiencing any of the following symptoms?

	Yes	No
• Fever	☐	☐
• Cough	☐	☐
• Recent Weight Loss	☐	☐
• Hemoptysis	☐	☐

_____
Applicant's Signature

Revised 7/1/22

Student Health Services
2020 Gravier Street - 7th Floor
New Orleans, Louisiana 70112
(504) 525-4839

REFUSAL OF MENINGITIS VACCINATION AND RELEASE FROM RESPONSIBILITY

BE IT KNOWN that on this date, I, _____
(Printed name of Student)

have decided voluntarily to disregard the medical advice of the qualified health professionals attending me on behalf of the University and the Louisiana Department or Health and Hospitals.

I AM REFUSING TO RECEIVE VACCINATION AGAINST MENINGITIS.

I HAVE BEEN FULLY INFORMED BY READING THE CENTERS FOR DISEASE CONTROL AND PREVENTION MENINGITIS VACCINE INFORMATION STATEMENT.

I understand the possible and probable adverse consequences of my refusal. I understand that my health could be negatively affected and possibly endangered by this refusal. The reason for my refusal is

_____

_____

_____

I declare myself to be a person of the full age of majority and to be mentally competent. I hereby assume full responsibility for any and all possible present or future results or complications of my condition due to this refusal.

I do further hereby now and forever free and release the University and the Department of Health and Hospitals and all its agents, attending health care professionals, and other personnel from any and all legal or financial responsibility as a result of this refusal.

I certify that I have read (or had read to me) and that I fully understand this Refusal of Treatment and Release from Responsibility. All explanations were made to me and all blanks filled in before I signed my name. I have refused this vaccination of my own free will.

_____ _____ am/pm
Month Day Year

_____
Printed Name Signature

PLEASE RETURN COMPLETED FORM TO: studenthealthstaff@lsuhsc.edu

Revised 7/1/22