

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 _____ 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: _____

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 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

PLEASE RETURN COMPLETED FORM TO: studenthealthstaff@lsuhsc.edu

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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**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 of 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

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