



# PROOF OF IMMUNIZATION COMPLIANCE

Louisiana R.S. 17:170/Schools of Higher Learning  
Phone: (225) 578-0593 Fax: (225) 578-5282 Email: immunization@lsu.edu  
150 B Infirmary Rd. Baton Rouge LA 70803

Name: \_\_\_\_\_ Semester of Enrollment: \_\_\_\_\_  
Please Print (Last) (First) (M.I.)

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

Date of Birth: \_\_\_\_\_ LSU ID Number: 89-\_\_\_\_-\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

## THIS MUST BE COMPLETED BY A PHYSICIAN OR HEALTH CARE PROVIDER

### Required Immunizations (NO ATTACHMENTS ACCEPTED IN PLACE OF BELOW)

|   |   |  |
|---|---|--|
| <b>MMR (Measles, Mumps, Rubella) - Two doses required</b><br>(Two doses of MMR at least 28 days apart. First dose after 12 months of age. May submit titers for proof of immunization.) |   | <b>Tetanus - One of below doses (Must be within the last 10 years)</b> |
| First Dose: _____<br>(Date mm/dd/yy)  | <b>OR</b><br>Serologic Test: _____<br>(Date mm/dd/yy) | Last Dose: _____<br>(Date mm/dd/yy)                                    |
| Second Dose: _____<br>(Date mm/dd/yy)   | Results: _____<br>(Provide copy of results)           | Circle type: TD or TDAP  |
| <b>Meningitis – One dose required at 16 years of age or older.</b>  |   |  |
| Quadrivalent vaccine A, C, Y, W-135 Last Dose: _____<br>(Date mm/dd/yy)   |   |  |
| Circle type: Menactra or Menveo   |   |  |

### Other Immunizations (Not Required)

| Vaccine  | Date Received mm/dd/yy | Date Received mm/dd/yy | Date Received mm/dd/yy | Date Received mm/dd/yy | Date Received mm/dd/yy | Write date of Titer if immune and provide copy of results. |
|--|------------------------|------------------------|------------------------|------------------------|------------------------|--|
| Specify Polio OPV <input type="checkbox"/><br>Type: Polio IPV <input type="checkbox"/> |                        |                        |                        |                        |                        |  |
| Hib  |                        |                        |                        |                        |                        |  |
| Hepatitis A  |                        |                        |                        |                        |                        |  |
| Hepatitis B  |                        |                        |                        |                        |                        |  |
| HPV  |                        |                        |                        |                        |                        |  |
| Influenza  |                        |                        |                        |                        |                        |  |
| Pneumococcal   |                        |                        |                        |                        |                        |  |
| Typhoid  |                        |                        |                        |                        |                        |  |
| Varicella  |                        |                        |                        |                        |                        |  |

\_\_\_\_\_  
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 campus and from classes in the event of an outbreak of measles, mumps, rubella, or meningitis 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 also sign below.

\_\_\_\_\_  
Student's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Legal Guardian, if required

\_\_\_\_\_  
Date

# TUBERCULOSIS QUESTIONNAIRE

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ ID Number: 89 - \_\_\_\_ - \_\_\_\_

**SECTION ONE: Please answer the following questions:**

|                        |                                   |                   |                            |                                  |   |                     |                                    |
|------------------------|-----------------------------------|-------------------|----------------------------|----------------------------------|---|---------------------|------------------------------------|
| Afghanistan            | Cabo Verde                        | Ecuador           | India                      | Mali                             | Pakistan                                | Seychelles          | Ukraine                            |
| Algeria                | Cambodia                          | El Salvador       | Indonesia                  | Marshall Islands                 | Palau                                   | Singapore           | United Rep. of                     |
| Angola                 | Cameroon                          | Equatorial Guinea | Iran                       | Mauritania                       | Panama                                  | Sierra Leone        | Tanzania                           |
| Argentina              | Central African Republic          | Eritrea           | Iraq                       | Mauritius                        | Papua New Guinea                        | Solomon Islands     | Uruguay                            |
| Armenia                | Chad                              | Estonia           | Kazakhstan                 | Mexico                           | Paraguay                                | Somalia             | Uzbekistan                         |
| Azerbaijan             | China                             | Ethiopia          | Kenya                      | Micronesia (Federated States of) | Peru                                    | South Africa        | Vanuatu                            |
| Bangladesh             | China, Hong Kong SAR              | Fiji              | Kiribati                   | Mongolia                         | Philippines                             | South Sudan         | Venezuela (Bolivarian Republic of) |
| Belarus                | Gabon                             | France            | Kuwait                     | Montenegro                       | Poland                                  | Sri Lanka           | Vietnam                            |
| Belize                 | Gambia                            | Guinea            | Kyrgyzstan                 | Morocco                          | Portugal                                | Sudan               | Yemen                              |
| Benin                  | China, Macao SAR                  | Georgia           | Lao People's Dem. Republic | Mozambique                       | Qatar                                   | Suriname            | Zambia                             |
| Bhutan                 | Colombia                          | Ghana             | Latvia                     | Myanmar                          | Republic of Korea                       | Swaziland           | Zimbabwe                           |
| Bolivia                | Comoros                           | Greenland         | Lesotho                    | Namibia                          | Republic of Moldova                     | Tajikistan          |                                    |
| Bosnia and Herzegovina | Cote d'Ivoire                     | Guam              | Liberia                    | Nauru                            | Romania                                 | Thailand            |                                    |
| Botswana               | Democratic People's Rep. of Korea | Guatemala         | Libya                      | Nepal                            | Russian Federation                      | Timor-Leste         |                                    |
| Brazil                 | Guinea                            | Guinea-Bissau     | Lithuania                  | Nicaragua                        | Rwanda                                  | Togo                |                                    |
| Brunei Darussalam      | Dem. Republic of Congo            | Guyana            | Madagascar                 | Niger                            | Saint Vincent and the Grenadine Islands | Trinidad and Tobago |                                    |
| Bulgaria               | Djibouti                          | Haiti             | Malawi                     | Nigeria                          | Sao Tome and Principe                   | Tunisia             |                                    |
| Burkina Faso           | Dominican Republic                | Honduras          | Malaysia                   | Northern Mariana Islands         | Senegal                                 | Turkmenistan        |                                    |
| Burundi                |                                   |                   | Maldives                   |                                  | Serbia                                  | Tuvalu              |                                    |
|                        |                                   |                   |                            |                                  |   | Uganda              |                                    |

1. Were you born in, have you ever lived in, or recently traveled to (within the past 5 years) any of the countries listed above that have a high incidence of active TB disease? (If yes, please CIRCLE the country)  Yes  No
2. Do you have a personal history of cancer, leukemia, kidney disease, diabetes, alcoholism, or intravenous drug use? (Family history does not apply)  Yes  No
3. Have you been a resident, employee, or volunteer in a prison, homeless shelter, hospital, nursing home, or other long-term treatment facility?  Yes  No
4. Do you have AIDS/HIV or take immunosuppressive medication such as prednisone?  Yes  No
5. Have you ever had close contact with persons known or suspected to have active TB disease?  Yes  No

If the answer to all of the above questions is NO, no TB testing or further action is required.

If the answer is YES to any of the above questions, LSU requires that you receive TB testing. The PPD skin test must be done within the 12 months prior to beginning your classes. You can obtain the PPD skin test from your local health care provider. (See Section two below)

**SECTION TWO: Test Results**

**Step 1: Tuberculin Skin Test – Positive if  $\geq 10$ mm for questions 1, 2, or 3 or  $\geq 5$ mm for questions 4 or 5.**

Date Given: \_\_\_\_\_ Date Read: \_\_\_\_\_ Result: \_\_\_\_\_ mm of Induration Interpretation: Positive \_\_\_\_\_ Negative \_\_\_\_\_

**Step 2: A QFT or T-SPOT is required if PPD is positive. A Chest X-Ray will not be accepted in its place.** (Please provide a copy of results.)

Date Obtained: \_\_\_\_\_ Circle Method Given: QFT T-Spot Result: Positive \_\_\_\_\_ Negative \_\_\_\_\_

**Step 3: Students with a positive QFT or T-Spot should receive a Chest X-Ray.**

Date of X-ray: \_\_\_\_\_ Result: Normal \_\_\_\_\_ Abnormal \_\_\_\_\_

**Step 4: Students with a positive QFT or T-Spot with no signs of active disease on chest x-ray are recommended to be treated for Latent TB with appropriate medication.**

Name of Medications for treatment: \_\_\_\_\_ Date Initiated & Duration of treatment: \_\_\_\_\_ (Please provide copy of completion of treatment.)

\_\_\_\_\_ Student has been treated or agrees to receive treatment.

\_\_\_\_\_ Student declines treatment at this time and agrees to come in to the Student Health Center to sign the "Refusal of Treatment for Latent TB". Student also agrees to routine checkups to monitor progression of Latent TB.

Health Care Provider's Name, Address, Phone #: \_\_\_\_\_

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.**

Please upload the completed form to the Patient Portal. It can be accessed on the Student Health Center homepage, [www.lsu.edu/shc](http://www.lsu.edu/shc). Students can log-on to the portal using their myLSU log-on information. Compliance can also be confirmed through the portal after the form has been reviewed and the information verified.

The completed form can also be submitted in person, by mail, by fax or by email to:

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

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

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