Name: __________________________________________ Semester of Enrollment: ____________________

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)**

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Date Received mm/dd/yy</th>
<th>Date Received mm/dd/yy</th>
<th>Date Received mm/dd/yy</th>
<th>Date Received mm/dd/yy</th>
<th>Write date of Titer if immune and provide copy of results.</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMR (Measles, Mumps, Rubella) - Two doses required (Two doses of MMR at least 28 days apart. First dose after 12 months of age. May submit titers for proof of immunization.)</td>
<td>First Dose: __________ (Date mm/dd/yy)</td>
<td>OR Serologic Test: _______ (Date mm/dd/yy)</td>
<td>Results: __________ (Provide copy of results)</td>
<td>Last Dose: _______ (Date mm/dd/yy)</td>
<td>Circle type: TD or TDAP</td>
</tr>
<tr>
<td>Tetanus - One of below doses (Must be within the last 10 years)</td>
<td>First Dose: __________ (Date mm/dd/yy)</td>
<td>OR Serologic Test: _______ (Date mm/dd/yy)</td>
<td>Results: __________ (Provide copy of results)</td>
<td>Last Dose: _______ (Date mm/dd/yy)</td>
<td>Circle type: TD or TDAP</td>
</tr>
<tr>
<td>Meningitis – One dose required at 16 years of age or older.</td>
<td>Quadrivalent vaccine ACYW-135 Last Dose: _______ (Date mm/dd/yy)</td>
<td>Circle type: Menactra or Menceo</td>
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</tr>
</tbody>
</table>

**Other Immunizations (Not Required)**

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<tr>
<th>Vaccine</th>
<th>Date Received mm/dd/yy</th>
<th>Date Received mm/dd/yy</th>
<th>Date Received mm/dd/yy</th>
<th>Date Received mm/dd/yy</th>
<th>Write date of Titer if immune and provide copy of results.</th>
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<tr>
<td>Specify Polio OPV □</td>
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<tr>
<td>Type: Polio IPV □</td>
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<td>Hepatitis B</td>
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<td>HPV</td>
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<tr>
<td>Influenza</td>
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<tr>
<td>Pneumococcal</td>
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<td>Typhoid</td>
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<tr>
<td>Varicella</td>
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</tbody>
</table>

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 https://www.cdc.gov/vaccines/vpd/index.html 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.

_________________________________________ Date __________

Parent or Legal Guardian, if required Date __________
TUBERCULOSIS QUESTIONNAIRE

Name: ___________________________ Date of Birth ___________________ ID Number: 89 - _ _ _ - _ _ _

SECTION ONE: Please answer the following questions:

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

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 (Must be completed by a Physician or Health Care Provider.)

Step 1: Tuberculin Skin Test – Positive if ≥ 10mm for questions 1, 2, 3, or 4 or ≥ 5mm for questions 5 or 6.

Date Given: ___________ Date Read: ___________ Result: _____ mm of Induration Interpretation: Positive____ Negative____

Step 2: A QFT or T-SPOT is required if PPD is positive. (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. (X-Ray’s will not be accepted in place of a PPD or QFT/TSPOT.)

Date of X-ray: ___________ Result: Normal_______ Abnormal_______ (Please provide a copy of results.)

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, 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 Email: immunization@lsu.edu
Immunizations Fax: (225) 578-5282
150-B Infirmary Road Tel: (225) 578-0593
Baton Rouge, LA 70803 Web: www.lsu.edu/shc Revised 01/2020