# 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)**

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

**Meningitis – One dose required at 16 years of age or older.**

Quadrivalent vaccine ACYW-135 Last Dose: _____ (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 □<br>Type: Polio IPV □ | | | | | | |
| 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 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.

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

1. Were you born in one of the countries listed above? (If yes, please CIRCLE the country) ☐ Yes ☐ No
2. Have 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 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)

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**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
Immunizations
150-B Infirmary Road
Baton Rouge, LA 70803

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

Revised 01/2020