STUDENT HEALTH SERVICES

LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER
2020 GRAVIER STREET
NEW ORLEANS, LOUISIANA 70112

School_____
Program_____
Entrance Date_____
Month Year

FULL AND PRECISE INFORMATION IS A REQUIREMENT FOR REGISTRATION.
EACH QUESTION MUST BE ANSWERED. INCOMPLETE RECORDS ARE NOT ACCEPTED.

PRINT OR TYPE ALL INFORMATION

Name (in full) _____
Last First Middle or Maiden

Address _____Telephone ( ) _____ - _____

Birthdate_____ Marital Status_____ Sex_____ Social Security No.; _____-_____-_____

PERSON TO BE NOTIFIED IN THE EVENT OF SERIOUS ACCIDENT OR ILLNESS:

Name (in full) _____Relationship_____

Address _____Telephone ( ) _____-_____

Office Address _____Telephone ( ) _____-_____

YOUR FAMILY PHYSICIAN

Name _____Office Telephone ( ) _____- _____

Office Address_____

Do you have Health or Accident Insurance? □ Yes □ No If yes, identify the Insurance Company:

Name of Company Company Address Policy No.

Date _____ Student's Signature_____

MEDICAL CONSENT---<u>IMPORTANT</u>

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.

Date _____Student's Signature _____

_____ _____ _____
Last First Maiden

TEST AND IMMUNIZATIONS

Dates of immunizations must be specified and reports of all labs and titers must be attached.

The following blood tests are **MANDATORY**

1. Varicella Titer Date _____ Titer_____ Varivax 1 Date _____

Varivax 2 Date _____

The following requirements must be satisfied by titers AND documentation of two (2) MMR immunizations (after age 1 year). If titers are low or negative; must show proof of two vaccines and a booster. If record of two MMR vaccines is unavailable, the positive titers are sufficient.

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 Titers are negative, you must show proof of vaccines and also proof of a booster.

The dates of each of the following must be specified

5. Tetanus/Diphtheria with Pertussis (within 10 years) Date _____
6. Hepatitis B vaccine dates 1st _____ 2nd _____

3rd _____

Hepatitis B Surface AB Titer **(Quantitative)** _____ **(Required)**

7. Tuberculin Skin Test (within 1 year) Date _____ Result _____
8. If the Tuberculin Skin Test is known to be positive, a chest x-ray is required within the past 6 months. (See page)

Date _____ Result _____

9. T-Spot or Quantiferon Gold Date_____ Result_____
10. Meningitis Vaccine #1 Date _____ Meningitis Vaccine #2 Date _____
(If before age 16)
11. Flu Vaccine Date _____ **(Only during Flu Season)**
12. COVID-19 Vaccines Name _____ and Date #1 _____#2 Date _____ Booster _____

If for some reasons this student is unable to take immunizations, please explain. _____
(See Attached Document)

SUMMARY OF IMMUNIZATIONS

Physician's name (please print) _____

Address _____ Telephone ( ) _____

Physician's signature _____Date _____

PLEASE RETURN COMPLETED FORM TO: LSUHSC Student Health Services
Attn: Phyllis P. Johnston
2020 Gravier Street, Room 789
New Orleans, LA 70112

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**

LSU Health New Orleans
HEALTH SCIENCES CENTER

TUBERCULOSIS SCREENING
PPD SCREENING FOR POSITIVE TEST ONLY
(This form should be completed by your health care provider)

Name of applicant: _____ **Date:** _____

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

A yearly symptom review is required for all positive testing.

Are you currently experiencing any of the following symptoms?

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

_____
Applicant's Signature