



# PROOF OF IMMUNIZATION COMPLIANCE

Louisiana R.S. 17:170/Schools of Higher Learning

Please Print

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

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

Date of Birth: \_\_\_\_\_ ID Number: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

## IMMUNIZATION REQUIREMENTS FOR LSU STUDENTS

**THIS MUST BE COMPLETED BY A PHYSICIAN OR HEALTH CARE PROVIDER - NO ATTACHMENTS ACCEPTED**

### REQUIREMENTS:

#### MMR (Measles, Mumps, Rubella)

(Two Doses Required)

Date of 1<sup>st</sup> dose: \_\_\_\_\_

Date of 2<sup>nd</sup> dose: \_\_\_\_\_

or

#### MEASLES

(Two Doses Required)

Date of 1<sup>st</sup> dose: \_\_\_\_\_

Date of 2<sup>nd</sup> dose: \_\_\_\_\_

#### MUMPS

(At least One Dose Required)

Date: \_\_\_\_\_

#### RUBELLA

(At least One Dose Required)

Date: \_\_\_\_\_

AND

#### TETANUS-DIPHTHERIA

(One Dose Required Within 10 years)

Date: \_\_\_\_\_

AND

#### MENINGITIS

(One Dose of Menactra Anytime or a Dose of Menomune Within the Past Year)

Date: \_\_\_\_\_

Vaccine type: \_\_\_\_\_

\_\_\_\_\_  
*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, or rubella 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 sign below.

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

\_\_\_\_\_  
*Date*

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

\_\_\_\_\_  
*Date*

Name: \_\_\_\_\_ ID Number: \_\_\_\_\_

**TUBERCULOSIS QUESTIONNAIRE**  
(MANDATORY – NO EXEMPTIONS)

The Student Health Center is evaluating all entering students for exposure to tuberculosis (TB). Please review and complete the information below **even if you have received a BCG (TB) vaccination in the past**. If you have any questions, please contact the Student Health Center at (225) 578-0593.

**PAST HISTORY**

- |  | YES   | NO    |
|--|-------|-------|
| 1. Were you born in, have you ever lived in, or recently traveled to (within the past 5 years) any country in the following areas of the world?<br><i>Africa, Asia, Caribbean nations, Central America (including Mexico), Eastern Europe, India and other Indian Subcontinent Nations, Middle East, Portugal, South America, South Pacific (except Australia and New Zealand), or Spain</i> | _____ | _____ |
| 2. Do you have a history of cancer, leukemia, kidney disease, diabetes, alcoholism, or intravenous drug use?   | _____ | _____ |
| 3. Have you resided, worked or volunteered in a prison, homeless shelter, hospital, nursing home, or other long-term treatment facility?   | _____ | _____ |
| 4. Do you have AIDS/HIV or take immunosuppressive medication such as prednisone?   | _____ | _____ |
| 5. Have you been in close contact with someone with TB?  | _____ | _____ |

**IMPORTANT:** If you have answered “**YES**” to any of these questions, you are required to have a PPD skin test **within the past year** before you can pay University fees. You can obtain the PPD skin test from your physician or public health clinic.

**NOTE TO HEALTH CARE PROVIDERS:** Please record the size of the induration in millimeters. If there is no reaction, please record as “0 mm”. **Students who have had a BCG vaccine are still required to have a PPD skin test.** If the screening skin test is positive (10mm or greater for those who answer “YES” to questions 1, 2, or 3, and 5mm or greater for those who answer “YES” to questions 4 or 5), we recommend the QuantiFERON-TB Gold (QFT) blood test to confirm the student has actually been exposed to TB in the past. A chest x-ray is required, if the QFT test is also positive. **PLEASE FOLLOW THE CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) GUIDELINES FOR THE TREATMENT OF LATENT TUBERCULOSIS INFECTION (LTBI) – SEE [WWW.CDC.GOV](http://www.cdc.gov).**

Date PPD Applied: \_\_\_\_\_ Date PPD Read: \_\_\_\_\_ Size of Induration: \_\_\_\_\_ mm

Date of QFT: \_\_\_\_\_ Result: Negative \_\_\_\_\_ Positive \_\_\_\_\_

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

Name of Medication: \_\_\_\_\_ Date Initiated: \_\_\_\_\_

Health Care Provider’s Name: \_\_\_\_\_

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.

**RETURN THIS FORM TO:** LSU Student Health Center  
Immunizations  
150-B Infirmary Road  
Baton Rouge, LA 70803

Telephone (225) 578-0593  
Fax (225) 578-5282  
[www.lsu.edu/shc](http://www.lsu.edu/shc)