

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

MEDICAL HISTORY: Students are to complete this section very carefully. In the event of a medical emergency such information will be valuable. Your report will be available only to Student Health Services and appropriate administrative officers of the school.

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 _____

History Heart Disease Hypertension Diabetes Kidney Disease Emotional Problems
 Communicable Diseases Illnesses Injuries Operations ADD/ADHD

Specify _____

Are you allergic to any medications, drugs, or foods? (Specify) _____

Medications taken regularly _____

Do you use (Yes or No) Alcohol _____ Tobacco _____ Drugs _____

Do you have any disabilities _____ Explain _____

Do you use any of the following? Yes No If yes, check appropriately and explain. Hearing Aid _____

Wheelchair _____ Eyeglasses, contact lens _____ Crutches _____

Artificial limb or eye _____ Braces: extremity or back _____

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---IMPORTANT

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 _____

MEDICAL EXAMINATION

(To be completed by physician not more than 90 days before registration)

Height _____ Weight _____ Blood pressure (sitting) _____ Pulse (sitting) _____ Resp _____

CHECK EACH ON THE APPROPRIATE COLUMN:

	NORMAL	ABNORMAL	COMMENTS
Head, Face, Scalp, Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neck, Nodes, Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes, Ears, Nose, Sinuses	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mouth and Teeth	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pharynx and Tonsils	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs and Chest	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abdomen, Hernia, Scars	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genitalia and Rectum (if indicated)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Extremities	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spine and Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological Reflexes	<input type="checkbox"/>	<input type="checkbox"/>	_____

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 may be satisfied by EITHER titers OR documentation of two (2) MMR immunizations (after age 1 year)

2. Measles Titer Date _____ Titer _____ MMR #1 Date _____
 3. Mumps Titer Date _____ Titer _____ MMR #2 Date _____
 4. Rubella Titer Date _____ Titer _____

The dates of each of the following must be specified

5. Tetanus/Diphtheria (within 10 years) Date _____
 6. Hepatitis B vaccine dates 1st _____ 2nd _____
 3rd _____
 If immune Hepatitis B Surface AB Titer _____

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.
 Date _____ Result _____
 9. Meningitis Vaccine (within 10 years) Date _____

If for some reasons this student is unable to take immunizations, please explain. _____

SUMMARY OF PHYSICAL EXAMINATION

Physician's name (please print) _____

Address _____ Telephone () _____ - _____

Physician's signature _____ Date of Examination _____

PLEASE RETURN COMPLETED FORM TO: LSUHSC Student Health Services
 2020 Gravier Street
 New Orleans, LA 70112