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STUDENT HEALTH SERVICES
478 S. JOHNSON ST – 3RD FLOOR
NEW ORLEANS, LOUISIANA 70112

Entering School of (select one):
◯ Allied Health ◯ Dentistry ◯ Medicine ◯ Nursing ◯ Public Health (joint MD/MPH)

Program____________________________ Entrance Date (Month & Year) ______________________

FULL AND PRECISE INFORMATION IS A REQUIREMENT FOR REGISTRATION.
EACH QUESTION MUST BE ANSWERED. INCOMPLETE RECORDS WILL RESULT IN A HEALTH BLOCK.

PERSONAL INFORMATION - PLEASE PRINT OR TYPE ALL INFORMATION.

Name ____
Last First Middle or Maiden

Address ____Telephone ( ) _______ - ____________

Date of Birth _______________ Marital Status_________________ Sex_________ Social Security No: ________-_____-__________

EMERGENCY CONTACT IN THE EVENT OF SERIOUS ACCIDENT OR ILLNESS:

Name ____Relationship__________________________

Address ____ Telephone ( ) _______-____________

PRIMARY CARE PHYSICIAN

Name ____ Office Telephone ( ) _______- ____________

Office Address____

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.

Student's Signature _____________________________________ *Date:* ______________________

Revised 12/1/22

____ __________________

Last First Middle or Maiden DOB

IMMUNIZATION HISTORY AND LAB WORK

All blood tests/titers are MANDATORY and this form must be completed and signed by a physician or healthcare provider.

Dates of immunizations must be specified and you MUST ATTACH documentation of all blood work and titers.

If titers are negative, you must show proof of booster or repeated vaccine series (if required).

1. Varicella Titer Date __________________Titer results______________________Varivax #1 Date ________________

   Varivax #2 Date ________________

2. Measles Titer Date __________________ Titer results ______________________ MMR #1 Date _________________
3. Mumps Titer Date __________________ Titer results ______________________ MMR #2 Date _________________
4. Rubella Titer Date __________________ Titer results ______________________ MMR #3 Date _________________ (If required)
5. Tetanus/Diphtheria with Pertussis (within last 10 years) Date _____________________
6. Hepatitis B vaccine dates 1st _______________________ 2nd ________________________

   3rd _______________________ (If required) Repeat #1____________________ #2____________________

7. Hepatitis B Surface Antibody Titer **(QUANTITATIVE)** Date: ____________ Result: ____________ **(numerical value required)**

8. Tuberculin Skin Test (within 1 year) Date ________________Result _____________ TB form attached (circle) Y or N

   OR

   T-Spot or Quantiferon Gold (within 1 year) Date ________________Result ______________

*If the Tuberculin Skin Test is known to be positive, a chest x-ray is required within the past 6 months + yearly symptoms review.

Date _____________________ Result ______________

10. Meningitis Vaccine (within last 10 years) Date _____________________

11. Flu Vaccine Date _____________________ **(If entering during flu season; Annual flu or waiver due by Nov 1)**

12. COVID-19 Vaccine Manufacturer Name ____________________

#1 (Date) ____________ #2 (Date) ____________ Booster (Date) ____________ Additional Doses (Date) _________________

*Meningitis and flu vaccination declination/waivers attached if necessary
*COVID exemption requests must be submitted via LSUHSC website on the Coronavirus page

HEALTHCARE PROVIDER CERTIFICATION:

Provider's name (please print) ____

Address ____ Telephone: ( ) ________________

Provider's signature ____ Date: ______________

PLEASE RETURN COMPLETED FORM TO: studenthealthstaff@lsuhsc.edu

LSU Health NEW ORLEANS

STUDENT HEALTH SERVICES
478 S. JOHNSON ST. – 3RD FLOOR
NEW ORLEANS, LA 70112
OFFICE (504) 568-1800
FAX 504-568-1799

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**

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LSU Health NEW ORLEANS

TUBERCULOSIS SCREENING

Annual form only required after positive PPD or bloodwork

(This form should be completed by your health care provider)

Name: ______________________________ **Date:** ________________

PPD 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

Are you currently experiencing any of the following symptoms?

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

____

Applicant's Signature

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Revised 12/1/22