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 _____

_____ _____ _____
Last First Middle or Maiden

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	☐	☐	_____
Neck, Nodes, Thyroid	☐	☐	_____
Eyes, Ears, Nose, Sinuses	☐	☐	_____
Mouth and Teeth	☐	☐	_____
Pharynx and Tonsils	☐	☐	_____
Lungs and Chest	☐	☐	_____
Breast	☐	☐	_____
Heart	☐	☐	_____
Abdomen, Hernia, Scars	☐	☐	_____
Genitalia and Rectum (if indicated)	☐	☐	_____
Extremities	☐	☐	_____
Spine and Musculoskeletal	☐	☐	_____
Neurological Reflexes	☐	☐	_____

_____ _____ _____
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 4)

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)**

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
Attn: Phyllis P. Johnston
2020 Gravier Street, Room 789
New Orleans, LA 70112

LSU Health NEW ORLEANS
School of Nursing

PPD SCREENING FOR POSITIVE TEST ONLY!

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

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

Provide documentation of PPD testing within the past 12 months:

Date: _____ **PPD Result:** _____ **mm**

If PPD positive, document:

1) **Date of positive PPD testing:** _____

2) **Treatment:** _____ **Dates:** _____

3) **Chest X-Ray:** _____ **Dates:** _____
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