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:* _____

_____ _____

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 UPLOAD COMPLETED FORM TO: THE STUDENT HEALTH SUBMISSION PORTAL
*Go to the LSU Health New Orleans Homepage, click MYLSUHSC>Self Service>Academic Self-Service, you must login and continue to upload your completed form.

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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Revised 2/20/24

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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