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

LSU Health NEW ORLEANS

Entering School of (select one):
◯ Graduate Studies ◯ Public Health (non medical)

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. Meningitis Vaccine (within last 10 years) Date _____
7. COVID-19 Vaccine Manufacturer Name _____

#1 (Date) _____ #2 (Date) _____ Booster (Date) _____ Additional Doses (Date) _____

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

HEALTH CARE 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.

Revised 2/20/24