PROOF OF IMMUNIZATION COMPLIANCE

Louisiana R.S. 17:170/Schools of Higher Learning

Phone: (225) 771-4770 Fax: (225) 771-6225
P.O. Box 10174 Helen Barron Drive Baton Rouge, LA 70813

Name:____ Semester of Enrollment:____________________
Please Print (Last) (First) (M.I.)

Address: ____ Email:______________________________
(Street/P.O. Box) (City) (State) (Zip Code)

Date of Birth:_______________ SU ID Number: S0-_ _ _-_ _ _ _ Telephone: (_____)___________________

THIS MUST BE COMPLETED BY A PHYSICIAN OR HEALTH CARE PROVIDER – NO ATTACHMENTS ACCEPTED

Vaccine	Date Received mm/dd/yy	Date Received mm/dd/yy	Date Received mm/dd/yy	Date Received mm/dd/yy	Date Received mm/dd/yy	Write date of lab test if immune and provide copy of results. If history of varicella write date and "disease".
Required Immunizations						
MMR – Measles Mumps Rubella: Two doses required (Two doses of MMR at least 28 days apart after 12 months of age. Those born before 1957 are exempt.)						
Tetanus – One of below doses. Specify Vaccine Type: **TD** □ **TDAP** □ **(Must be within the last 10 years)**						
Meningitis – ACYW-135 – One of below doses. Specify Type: **Menactra** □ **Menveo** □ **(Students 21 or under are required to have a dose at 16 or older. If over 21 dose can be given at any time.)** **Menomune** □ **(Must be within the last 12 months)**						
Other Immunizations (Not Required)						
Specify Vaccine: Polio OPV □ **Polio IPV** □						
Hib						
Hepatitis A						
Hepatitis B						
Influenza						
Pneumococcal						
Rotavirus						
Varicella						

____ ________________________
Signature of Health Care Provider *Date*

____ (_______) ________________
Address *Telephone*

Request for <u>Immunization</u> Exemption: If you request an immunization exemption for medical or personal reasons or due to an inability to locate a specific vaccine, please check the appropriate box and provide the requested information.

□ Medical (physician's statement required) □ Personal (state reason in space below) □ Shortage (unable to locate vaccine)

____

I have received and reviewed information from the Center for Disease Control and Prevention's (CDC's) website at http://www.cdc.gov/nip/publications/VIS/default.htm regarding vaccine preventable diseases and related vaccinations and have chosen not to be vaccinated. I understand that if I claim exemption for personal or medical reasons, I may be excluded from campus and from classes in the event of an outbreak of measles, mumps, rubella, or meningitis until the outbreak is over or until I submit proof of immunization. If I am not 18 years of age, my parent or legal guardian must also sign below.

______________________ __________ ______________________ __________
Student's Signature *Date* *Parent or Legal Guardian, if required* *Date*

TUBERCULOSIS QUESTIONNAIRE

Name: ______________________________ Date of Birth ______________ ID Number: SO - _ _ _ - _ _ _ _

SECTION ONE: Please answer the following questions:

Afghanistan
Algeria
Angola
Argentina
Armenia
Azerbaijan
Bahrain
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
Colombia
Comoros
Congo
Cote d'Ivoire
Democratic People's Rep. of Korea
Dem. Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
Fiji
Gabon
Gambia
Georgia
Ghana
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iran
Iraq
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Dem. Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Mexico
Micronesia (Federated States of)
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Niue
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Saint Vincent and the Grenadine Islands
Sao Tome and Principe
Senegal
Serbia
Seychelles
Singapore
Sierra Leone
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Swaziland
Tajikistan
Thailand
Timor-Leste
Togo
Trinidad and Tobago
Tunisia
Turkey
Turkmenistan
Tuvalu
Uganda
Ukraine
United Rep. of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

1. Were you born in, have you ever lived in, or recently traveled to (within the past 5 years) any of the countries listed above that have a high incidence of active TB disease? (If yes, please CIRCLE the country) ☐ Yes ☐ No
2. Do you have a personal history of cancer, leukemia, kidney disease, diabetes, alcoholism, or intravenous drug use? (Family history does not apply) ☐ Yes ☐ No
3. Have you been a resident, employee, or volunteer in a prison, homeless shelter, hospital, nursing home, or other long-term treatment facility? ☐ Yes ☐ No
4. Do you have AIDS/HIV or take immunosuppressive medication such as prednisone? ☐ Yes ☐ No
5. Have you ever had close contact with persons known or suspected to have active TB disease? ☐ Yes ☐ No

If the answer to all of the above questions is NO, no TB testing or further action is required.

If the answer is YES to any of the above questions, SUBR requires that you receive TB testing. The PPD skin test must be done within the 12 months prior to beginning your classes. You can obtain the PPD skin test from your local health care provider. (See Section two below)

SECTION TWO: Test Results

Step 1: Tuberculin Skin Test – Positive if ≥ 10mm for questions 1, 2, or 3 or ≥ 5mm for questions 4 or 5.
Date Given: _________ Date Read: _________ Result: _____ mm of Induration Interpretation: Positive____ Negative____

Step 2: A QFT or T-SPOT is required if PPD is positive. A Chest X-Ray will not be accepted in its place. (Please provide a copy of results.)
Date Obtained: _________ Circle Method Given: QFT T-Spot Result: Positive____ Negative____

Step 3: Students with a positive QFT or T-Spot should receive a Chest X-Ray.
Date of X-ray: _________ Result: Normal_________ Abnormal_________

Step 4: Students with a positive QFT or T-Spot with no signs of active disease on chest x-ray are recommended to be treated for Latent TB with appropriate medication.
Name of Medications for treatment: ________________ Date Initiated & Duration of treatment: _________ (Please provide copy of completion of treatment.)

_________ **Student has been treated or agrees to receive treatment.**

_________ **Student declines treatment at this time and agrees to come in to the Student Health Center to sign the "Refusal of Treatment for Latent TB". Student also agrees to routine checkups to monitor progression of Latent TB.**

Health Care Provider's Name, Address, Phone #: ____

Health Care Provider's Signature: ____

****REMEMBER! You will not be eligible to pay University fees or move into the dormitory until all immunization records are in compliance or the exemption is signed.**

Please fax or mail the completed form to the SU Baranco-Hill Health Center. It can be accessed on the Student Health Center homepage, http://www.subr.edu/index.cfm/page/14/n/45.

The completed form can also be submitted in person, by mail, and by fax:

SU Student Health Services **Fax: (225) 771-6225**
Baranco-Hill Health Center **Tel: (225) 771-4770**
P.O. Box 10174
Helen Barron Drive
Baton Rouge, LA 70813

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