

Please return the completed form to: University of Louisiana at Lafayette; Student Health Service:
PO Box 43692, Lafayette, LA 70504-3692, Fax: 337-482-1873

Name: _____ Date of Birth: _____ CLID/SSN: _____
(Last/Family) (First/Given)

When do you plan to start at UL Lafayette: _____ Month _____ Year

Email: _____ Telephone: _____

Instructions: Immunization requirements are applicable to students born on or after January 1, 1957. Sections A (and/or B) & C must be completed. You must either have a physician or health care provider complete Section A or submit the Universal Certificate of Immunizations provided by the Department of Health and Hospitals, Office of Public Health. If you have not been immunized for all required diseases, you may request an exemption by completing Section B. However, Section C cannot be waived and must be completed.
_____: Failure to complete _____ turn in this form will _____ you from being able to schedule classes.

Date of 1st dose: _____

Date of 2nd dose: _____

Date: _____

Vaccine type: _____

Date: _____

Date: _____

Date: _____

Vaccine type: _____

(Minimum interval is eight weeks)

Date: _____

Vaccine type: _____

I have chosen not to be vaccinated for _____ and am requesting an exemption, and I am aware of the risks.

Medical _____ Personal _____ Shortage (unable to locate vaccine) _____ Other: _____

I understand that if I claim an 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. I have reviewed information regarding vaccine-preventable diseases and related vaccinations contained on the website for the Center for Disease Control and Prevention (CDC): <http://www.cdc.gov/vaccines/hcp/vis/index.html>. If I am not 18 years of age or older, my parent or legal guardian must also sign below.

Student Signature

Date

Parent Signature
(for students under 18 years old)

Date

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Name: _____ Date of Birth: _____ CLID/SSN: _____
(Last/Family) (First/Given)

Country of Origin: _____

Instructions: Complete all questions in Section C, Part I.
• If the answer is _____ to questions, no further testing or action is required.
• If the answer is _____ to any of the below questions, you are required to have your physician or health care provider complete Section C, Part II. You are required to have a tuberculin skin test (PPD). You may use record of a previous PPD skin test if it was within the last 12 months. PPD skin tests can be obtained from your physician or walk-in clinic.
_____: Failure to complete _____ turn in this form will _____ you from being able to schedule classes.

1. Have you ever had close contact with persons known or suspected to have active TB disease?
2. Were you born in, have you ever lived in, or recently traveled (within the past 5 years for 2 hours or more) to a high risk country?
Africa, Asia, Central America (including Mexico), Eastern Europe, India and other Indian Subcontinent Nations, Middle East, Portugal, South America, South Pacific (except Australia and New Zealand)
3. Have you ever had a BCG (Tuberculosis vaccination)? If yes, date/year: _____

Instructions: Section C, Part II to be completed only if there is a _____ answer to any questions from Section C, Part I. Section C, Part II to be completed by physician or health care provider _____.

- Please review and verify the 3 questions from _____ completed by student.
 - Persons answering YES to any of the questions in _____ are required to have a Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented.
 - Refer to www.cdc.gov for interpretation of TST results:
 - o If TST is positive: IGRA is required
 - o If IGRA is positive: refer to public health
 - Results:
 - o TST (results should be based on actual millimeters (mm) of induration; if none, write "0 mm")
 - Date applied: _____ - _____ - _____ Date read: _____ - _____ - _____
 - mm of induration: _____ Interpretation: (circle one) _____ or _____
 - o IGRA
 - Date obtained: _____ - _____ - _____ Method: (circle or fill in blank) _____ or _____ or _____
 - Result: (circle one) _____ or _____ or _____ or _____ (T-Spot only)
 - Assessment: (please check)
 - _____ TST is negative: no further action is required.
 - _____ TST is positive and IGRA is negative: no further action is required.
 - _____ TST is positive and IGRA is positive: refer to public health (please specify) _____
- *Please notify patient that a letter from public health must be received in order to gain clearance for entrance to campus.

Signature of Physician or Health Care Provider

Address

City, State, Zip

Date

Telephone

Physician or Health Care Provider Stamp Here