PROOF OF IMMUNIZATION COMPLIANCE

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

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 **ONLY** 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. **No other attachments or photocopies accepted**. 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.

****IMPORTANT****: Failure to complete **AND** turn in this form will **PREVENT** you from being able to schedule classes.

Section A: Documentation of Immunizations

1. MMR (MEASLES, MUMPS, RUBELLA)
(Two Doses Required)
Date of 1st dose: _____
Date of 2nd dose: _____

AND

2. TETANUS
(One Dose Required Within 10 years)
Date: _____
Vaccine type: _____

AND

3. MENINGITIS
(One Dose of meningococcal vaccine)
Date: _____
Vaccine type: _____

OR

MEASLES
(Two Doses Required)
Date of 1st dose: _____
Date of 2nd dose: _____

MUMPS
(At least One Dose Required)
Date: _____

RUBELLA
(At least One Dose Required)
Date: _____

Physician or Health Care Provider Stamp Here

_____
Signature of Physician or Health Care Provider

_____
Address

_____
City, State, Zip

_____ _____
Date Telephone

Section B: Immunization Exemption Request

Instructions: Only complete Section B if you are choosing not to be vaccinated. Otherwise, please disregard.

I have chosen not to be vaccinated for and am requesting an exemption from one or more of the vaccination(s) listed in **Section A: Documentation of Immunizations**, and I am aware of the risks.

Vaccination(s) for which I am requesting exemption: _____

Reason for Immunization Exemption Request (please check one):

❑ 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: _____ **(Do NOT leave blank)**

Section C: Tuberculosis (TB) Screening and Targeted Testing

Instructions: Complete all questions in Section C, Part I.
- If the answer is **NO** to **ALL** questions, no further testing or action is required.
- If the answer is **YES** 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.

****IMPORTANT****: Failure to complete **AND** turn in this form will **PREVENT** you from being able to schedule classes.

Section C Part I: Tuberculosis (TB) Screening

1. Have you ever had close contact with persons known or suspected to have active TB disease? ❑ **yes** ❑ **no**
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? ❑ **yes** ❑ **no**
   Africa, Asia, Caribbean nations, Central America (including Mexico), Eastern Europe, India and other Indian Subcontinent Nations, Middle East, Portugal, South America, South Pacific (except Australia and New Zealand) or Spain
3. Have you ever had a BCG (Tuberculosis vaccination)? If yes, date/year: _____ ❑ **yes** ❑ **no**

Section C Part II: Tuberculosis (TB) Targeted Testing

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

Clinical Assessment by HealthCare Provider

- Please review and verify the 3 questions from **Section C, Part I** completed by student.
- Persons answering YES to any of the questions in **Section C, Part I** 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:
  - If TST is positive: IGRA is required
  - If IGRA is positive: refer to public health
- Results:
  - 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) **positive** or **negative**
  - IGRA
    - Date obtained: _____-_____-_____ Method: (circle or fill in blank) **QFT-GIT** or **T-Spot** or **Other**_____
    - Result: (circle one) **negative** or **positive** or **indeterminate** or **borderline** (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