



PROOF OF IMMUNIZATION COMPLIANCE

Louisiana R.S. 17:170/Schools of Higher Learning
Phone: (225) 578-0593 Fax: (225) 578-5282 Email: immunization@lsu.edu
150 B Infirmary Rd. Baton Rouge LA 70803

Name: Koch Benjamin Semester of Enrollment: _____
Please Print (Last) (First) (M.I.)

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

Date of Birth: 5/28/91 LSU ID Number: 89-____-____ Telephone: (____) _____

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

Required Immunizations

MMR (Measles, Mumps, Rubella) - Two doses required (Two doses of MMR at least 28 days apart. First dose after 12 months of age. May submit titers for proof of immunization.)		Tetanus - One of below doses (Must be within the last 10 years)
First Dose: <u>9-28-92</u> (Date)	OR Serologic Test: _____ (Date)	Last Dose: <u>5-19-17</u> (Date)
Second Dose: <u>9-26-96</u> (Date)	Results: _____ (Provide copy of results)	Circle type: TD or <u>TDAP</u>
Meningitis – One dose required at 16 years of age or older.		
Quadrivalent vaccine A, C, Y, W-135 Last Dose: <u>5-19-17</u> (Date)		
Circle type: <u>Menactra</u> or Menveo		

Other Immunizations (Not Required)

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 Titer if immune and provide copy of results.
Specify Polio OPV ☐						
Type: Polio IPV ☐						
Hib						
Hepatitis A						
Hepatitis B						
Influenza						
Pneumococcal						
Rotavirus						
Varicella						

L. Stewart, RN 5-19-17
Signature of Health Care Provider Date
AUBURN UNIVERSITY MONTGOMERY
STUDENT HEALTH CENTER
IRMA B. MOORE HALL RM. 102
P.O. BOX 244023
MONTGOMERY, AL 36124-4023
Address Telephone

Request for Immunization 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: Koch, Benjamin Date of Birth 5-28-91 ID Number: 89 - - - - -

SECTION ONE: Please answer the following questions:

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

- 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
- Do you have a personal history of cancer, leukemia, kidney disease, diabetes, alcoholism, or intravenous drug use? (Family history does not apply) ☐ Yes ☒ No
- Have you been a resident, employee, or volunteer in a prison, homeless shelter, hospital, nursing home, or other long-term treatment facility? ☐ Yes ☒ No
- Do you have AIDS/HIV or take immunosuppressive medication such as prednisone? ☐ Yes ☒ No
- 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, LSU 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 ≥ 10 mm for questions 1, 2, or 3 or ≥ 5 mm 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 #: Auburn SHC (334) 244-3281

Health Care Provider's Signature: James Stewart, CRNP

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

Please upload the completed form to the Patient Portal. It can be accessed on the Student Health Center homepage, www.lsu.edu/shc.

Students can log-on to the portal using their myLSU log-on information. Compliance can also be confirmed through the portal after the form has been reviewed and the information verified.

The completed form can also be submitted in person, by mail, by fax or by email to:

LSU Student Health Center
Immunizations
150-B Infirmary Road
Baton Rouge, LA 70803

Email: immunization@lsu.edu
Fax: (225) 578-5282
Tel: (225) 578-0593
Web: www.lsu.edu/shc

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