

**MAIL HEALTH FORM TO:**

Student Health Center  
Louisiana Tech University  
P.O. Box 3023  
Ruston LA 71272-0001



LOUISIANA TECH UNIVERSITY

For Office Use:

Coded \_\_\_\_\_  
Initials \_\_\_\_\_

This information is strictly for the use of the Student Health Center and will not be released to anyone without your knowledge and consent.

Please type or print. USE INK

Quarter for which you are applying - Fall/Winter/Spring/Summer: \_\_\_\_\_

Name (Mr.) (Mrs.) (Ms.) \_\_\_\_\_ Soc. Security # \_\_\_\_\_  
Last First Middle Maiden

Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Country of birth \_\_\_\_\_ Sex \_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Present Mailing Address \_\_\_\_\_  
Number Street City

State ZIP Telephone Number Major

Person to notify in case of emergency: \_\_\_\_\_ Relationship \_\_\_\_\_  
( )

Address Tel. No. (work) (home)

### IMMUNIZATION POLICY

Louisiana state law (Act 1047) requires that all persons who are entering Louisiana colleges and universities for the first time and whose date of birth falls after Dec. 31, 1956, to submit proof of immunization against preventable and/or communicable diseases, including measles, mumps, rubella, and tetanus-diphtheria (MMR, Td).

Louisiana Tech University requires all new students born after Dec. 31, 1956, to provide proof of immunization against MMR and Td. Forms for documenting immunization or establishing an exemption to this requirement are available from the Office of Admissions, Louisiana Tech University, Ruston LA 71272.

Failure to complete and return these forms will hinder completion of the registration process.

### LOUISIANA TECH UNIVERSITY REQUIRES PROOF OF THE FOLLOWING:

From all students born after Dec. 31, 1956:

- Proof of immunity to measles, mumps and rubella. Acceptable proof includes:
  - a) Protective serum titer for rubella if no documentation of immunization, and,
  - b) Record of immunization signed by a physician or documentation by physician of measles and mumps disease.
- MMR (first) date \_\_\_\_\_ (second) date \_\_\_\_\_
- A tetanus/diphtheria combination within the past 10 years.  
Tetanus/diphtheria combination: date \_\_\_\_\_

### LOUISIANA TECH UNIVERSITY RECOMMENDS THE FOLLOWING:

- Varicella vaccine or proof of disease: (first) date \_\_\_\_\_ (second) date \_\_\_\_\_  
or history of disease: Yes \_\_\_\_ No \_\_\_\_  
or varicella antibody: Month \_\_\_\_ Year \_\_\_\_ Reactive \_\_\_\_ Nonreactive \_\_\_\_
- Hepatitis B vaccine: (first) date \_\_\_\_\_ (second) date \_\_\_\_\_ (third) date \_\_\_\_\_  
or Hepatitis B surface antibody date: Month \_\_\_\_ Year \_\_\_\_ Result Reactive \_\_\_\_ Nonreactive \_\_\_\_
- Meningococcal vaccine: Date \_\_\_\_\_
- Influenza: Date \_\_\_\_\_
- Tuberculosis screening: PPD Date \_\_\_\_\_ Result positive \_\_\_\_ Negative \_\_\_\_  
If PPD is positive, chest X-ray required. X-ray result: Normal \_\_\_\_ Abnormal \_\_\_\_ Date \_\_\_\_\_

Information on immunizations must be authenticated by a physician, public health clinic, or transcript from school record.

A photocopy of an official immunization record will also be acceptable.

SIGNATURE AND STAMP OF FACILITY (required) \_\_\_\_\_

### CERTIFICATE OF MEDICAL EXEMPTION

Medical exemption: The above named student is hereby granted a medical exemption on the basis of certain specific health/physical conditions which are recognized contraindications to the administration of required vaccines.

1. Temporary Exemption Reason: \_\_\_\_\_

2. Permanent Exemption Reason: \_\_\_\_\_

If permanent exemption due to contraindicated vaccines, are all vaccines contraindicated: Yes \_\_\_\_ No \_\_\_\_

If no, designate specific vaccine: \_\_\_\_\_

Signature of student or parent \_\_\_\_\_ Date \_\_\_\_\_

Physician or health provider \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

## REQUEST FOR EXEMPTION — PERSONAL DISSENT

I am requesting exemption from compliance with Louisiana state law (Act 1047) for the following personal reasons:

\_\_\_\_\_

I understand if I claim exemption for personal or medical reasons, that in the event of an outbreak of measles, mumps, or rubella, I may be excluded from attendance of all campus activities, including classes, until the appropriate disease incubation period has expired or until I submit proof of immunization.

If I am not 18 years of age, my parent or legal guardian must sign below.

Student's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or guardian (if required): \_\_\_\_\_ Date: \_\_\_\_\_

## PERSONAL HISTORY

Please answer all questions. Comment on all positive answers in the space below or on an additional sheet.

Are you allergic to:	Yes	No	Have you ever had:	Yes	No
Penicillin			Appendectomy		
Sulfa drugs			Tonsillectomy		
Other drugs or medicine			Hernia repair		
Food			Bone or joint surgery		
Anesthesia			Tumor, cancer, cyst		
X-ray dyes			Gum or tooth disease		
Other			Sinusitis		
Have you ever had:			Eye disease		
Hepatitis			Ear, nose or throat disease		
Measles			Hay fever-asthma		
Mumps			Urticaria (hives)		
Chicken pox			Chest pain/pressure		
German measles (rubella)			Anemia		
Malaria					
Tuberculosis					
Infectious mononucleosis					

  

Have you ever had:	Yes	No	Have you ever had:	Yes	No
Shortness of breath			Back injury		
High blood pressure			Head injury with unconsciousness		
Palpitations (heart)			Diabetes		
Heart murmur or rheumatic fever			Seizures-epilepsy		
Lung disease			Depression or other emotional problems		
Chronic cough			Recurrent headaches		
Peptic ulcer disease			Bleeding disorder		
Gall bladder disease			Do you use tobacco?		
Chronic diarrhea or colitis			Alcohol? Other drugs?		
Kidney disease or blood or sugar in urine			Females Only		
Disease or injury of joints or bones			Irregular periods		
Sleep problems			Severe cramps		
			Excessive flow		
			Birth control		

## ADDITIONAL INFORMATION

	Yes	No
A. Are you currently taking any medicine on a regular basis? If so, list.		
B. Have you had any illness or injury or ever been hospitalized other than already noted? If so, list.		
C. Has your physical activity been restricted during the past five years? (Give reason).		
D. Have you been treated by clinics, physicians, or other therapists in the last five years other than already noted? If so, list.		

  

Comment on any items checked "yes" in this section.