

**Mail or Fax Health Form to:**

Student Health Center  
Louisiana Tech University  
P.O. Box 3023  
Ruston, LA 71272-0001  
Fax: (318) 257-3927

**LOUISIANA TECH  
UNIVERSITY**  
RUSTON, LA 71272

For Office Use:

Coded \_\_\_\_\_

Initials \_\_\_\_\_

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

**MEDICAL HISTORY**

Please type or print. USE INK

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

Name (Mr.) (Mrs.) (Ms.) \_\_\_\_\_ Student ID # \_\_\_\_\_  
Last First Middle

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

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

( )  
State Zip Code Telephone Number Major

Next of Kin or 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 is after 1956, must submit proof of immunization against preventable and/or communicable diseases, including Measles, Mumps, Rubella, and Tetanus-Diphtheria (MMR, Td).

Louisiana state law (Act 251) requires first time freshman to submit proof of immunization against meningitis beginning Fall 2006.

Louisiana Tech University requires all new students born after December 31, 1956 to provide proof of immunization against MMR, Td and Meningitis.

Failure to complete and return these forms will result in the inability to complete the registration process.

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

From all students born after December 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 stamped by a physician or documentation by physician of Measles and Mumps disease.

\*A Tetanus/Diphtheria combination within the past 10 years.

\*Meningitis vaccine for first time students entering college in Fall 2006 and thereafter.

\*Rubella vaccine: Date \_\_\_\_\_ or Rubella titer and date \_\_\_\_\_

\*Measles vaccine: (FIRST) Date \_\_\_\_\_ (SECOND) Date \_\_\_\_\_ or Measles disease: Date \_\_\_\_\_  
(Two Measles vaccines must be administered after January 1, 1968, and must have been given on or after the first birthday)

\*Mumps vaccine: Date \_\_\_\_\_ or Mumps disease: Date \_\_\_\_\_

\*Tetanus/Diphtheria combination: Date \_\_\_\_\_

\*Meningitis vaccine: 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) \_\_\_\_\_

ADDRESS STREET/PO BOX CITY STATE ZIP CODE

**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 contradictions 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, designated specific vaccine: \_\_\_\_\_

Signature of Student or Parent \_\_\_\_\_ Date \_\_\_\_\_

Physician or Health Provider \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Telephone No. \_\_\_\_\_

## REQUEST FOR EXEMPTION – PERSONAL DISSENT

I am requesting exemption from compliance with Louisiana state laws (Act 1047 and Act 251) 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, rubella or meningitis, 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: \_\_\_\_\_

### 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	Have you ever had:	Yes	No	Have you ever had:	Yes	No
Penicillin			Appendectomy			Shortness of breath			Head injury with unconsciousness		
Sulfa drugs			Tonsillectomy			High blood pressure			Diabetes		
Other drugs or medicine			Hernia repair			Palpitations (heart)			Seizures-epilepsy		
Food			Bone or joint surgery			Heart Murmur or Rheumatic fever			Depression or other emotional problems		
Anesthesia			Tumor, Cancer, Cyst			Lung disease			Recurrent headaches		
Other			Sinusitis			Chronic cough			Bleeding disorder		
Have you ever had:			Eye Disease			Peptic ulcer disease			Do you use tobacco?		
Hepatitis			Ear, nose, or throat disease			Gall Bladder disease			Alcohol? Other drug?		
Measles			Hay fever-asthma			Chronic diarrhea or colitis			Females Only		
Mumps			Uticaria (hives)			Kidney disease or blood or sugar in urine			Irregular periods		
Chicken Pox			Chest pain/pressure			Disease or injury of joints or bones			Severe cramps		
German measles (rubella)			Anemia			Sleep Problems			Excessive flow		
Malaria			Tuberculosis			Infectious Mononucleosis			Birth Control		

### ADDITIONAL INFORMATION

	Yes	No	
A. Are you presently taking any medicine on a regular basis? If so, list.			Comment on any items checked "Yes" in this Section
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.			
E. Have you ever been rejected for or discharged from military service or a civilian job because of physical or emotional reasons?			

Has anyone in your family ever had any of the following:	Yes	No	Relationship			
Tuberculosis						
Cancer, anemia, blood disease						
Diabetes						
Kidney Disease						
Heart Dis ,high blood pressure						
Arthritis						
Stomach Disease						
Asthma or hay Fever						
Epilepsy, Convulsions						
Mental Illness						

To avoid any delay in registration, please complete and return this form at least four weeks prior to registration. You will not be able to register until this form, including documentation of required immunizations, is complete and on file with the Student Health Center.