STUDENT HEALTH SERVICES
478 S. JOHNSON ST – 3RD FLOOR
NEW ORLEANS, LOUISIANA 70112

LSU Health NEW ORLEANS

Entering School of (select one):

◯ Allied Health ◯ Dentistry ◯ Medicine ◯ Nursing ◯ Public Health (joint MD/MPH)

Program_____Entrance Date (Month & Year) _____

FULL AND PRECISE INFORMATION IS A REQUIREMENT FOR REGISTRATION.
EACH QUESTION MUST BE ANSWERED. INCOMPLETE RECORDS WILL RESULT IN A HEALTH BLOCK.

PERSONAL INFORMATION - PLEASE PRINT OR TYPE ALL INFORMATION.

Name _____
Last First Middle or Maiden

Address _____Telephone ( ) _____- _____

Date of Birth _____Marital Status_____Sex_____Student ID#: ----------

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EMERGENCY CONTACT IN THE EVENT OF SERIOUS ACCIDENT OR ILLNESS:

Name _____Relationship_____

Address _____Telephone ( ) _____-_____

PRIMARY CARE PHYSICIAN

Name _____Office Telephone ( ) _____- _____

Office Address_____

MEDICAL CONSENT---IMPORTANT

In case of a medical emergency, call: ☐ University Physician ☐ Local personal physician

Local Physician's Name _____

Address _____Office Telephone ( ) _____- _____

If the attempt to reach my personal physician is unsuccessful, I authorize the University Physician to prescribe such treatment as he/she reasonably judges to be in my best interest and authorize him/her and those he/she directs to administer that treatment.

Student's Signature _____*Date:* _____

**PLEASE UPLOAD COMPLETED FORM TO: THE STUDENT HEALTH SUBMISSION PORTAL
*Go to the LSU Health New Orleans website, https://www.lsuhsc.edu, Click on MENU →MyLSUHSC → Self Service → Academic Self-Service then you must login and continue to upload your completed form.

Revised:11/21/24

Last _____ First _____ Middle or Maiden _____ DOB _____

IMMUNIZATION HISTORY AND LAB WORK

All blood tests/titers are MANDATORY and this form must be completed for verification of dates and titers.

Dates of immunizations must be specified and you **MUST ATTACH documentation of all blood work and titers.**

If titers are negative, you must show proof of booster or repeated vaccine series (if required).

1. Varicella Titer Date _____ Titer results _____ Varivax #1 Date _____

   Varivax #2 Date _____

2. Measles Titer Date _____ Titer results _____ MMR #1 Date _____

3. Mumps Titer Date _____ Titer results _____ MMR #2 Date _____

4. Rubella Titer Date _____ Titer results _____ MMR #3 Date _____ (If required)

5. Tetanus/Diphtheria with Pertussis (within last 10 years) Date _____

6. Hepatitis B vaccine dates 1st _____ 2nd _____

   3rd _____ (If required) Repeat #1 _____ #2 _____

7. Hepatitis B Surface Antibody Titer **(QUANTITATIVE)** Date: _____ Result: _____ **(numerical value required)**

8. Tuberculin Skin Test (within 1 year) Date _____ Result _____ TB form attached (circle) Y or N

   OR

   T-Spot or Quantiferon Gold (within 1 year) Date _____ Result _____

*If the TB Test is known to be positive, a chest x-ray is required within the past 6 months + yearly symptoms review.

Date _____ Result _____

10. Meningitis Vaccine (within last 10 years) Date _____

11. Flu Vaccine Date _____ **(If entering during flu season; Annual flu or waiver due by Nov 1)**

12. COVID-19 Vaccine Manufacturer Name _____

#1 (Date) _____ #2 (Date) _____ Booster (Date) _____ Additional Doses (Date) _____

***For Refusal of Meningitis and Flu; a Refusal of Vaccination Form must be completed and uploaded!**

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STUDENT HEALTH SERVICES
478 S. JOHNSON ST. – 3RD FLOOR
NEW ORLEANS, LA 70112
OFFICE (504) 568-1800
FAX 504-568-1799

Annual TB Skin Test

Name: _____
Last First

DOB: _____

Program: AH DS GS MED NUR

Date Administered: _____

Test Site: _____

Administered by: _____

Patient instructed and agreed to return to clinic within 48-72 hours for reading of TB skin test _____
Initial here

For office use only

Result: NEG@_____mm POS@_____mm _____ _____
Date Read & Time **Name of Person**

☐ **CXR** **Neg** **Pos**

☐ **INH** ☐ **Student Health to manage INH**

☐ **Wetmore to manage INH**

☐ **TB sx discussed w/pt**

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LSU Health NEW ORLEANS

TUBERCULOSIS SCREENING

Annual form only required after positive PPD or bloodwork

(This form should be completed by your health care provider)

Name: _____ **Date:** _____

PPD Date: _____ **PPD Result:** _____**mm**

Quantiferon Gold or T-Spot **Date:**_____**Result** _____**mm**

If PPD/Quantiferon Gold or T-Spot Positive:

1) **Date of positive testing:** _____

2) **Treatment:** _____ **Dates:** _____

3) **Chest X-Ray:** _____ **Date:** _____
Results within past 24 months

_____ _____
Screening Practitioner's Name (Print) **Date**

_____
Screening Practitioner's Signature

Are you currently experiencing any of the following symptoms?

	Yes	No
• Fever	☐	☐
• Cough	☐	☐
• Recent Weight Loss	☐	☐
• Hemoptysis	☐	☐

_____
Applicant's Signature

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