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: *C00_____
(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
(Two Doses of meningococcal vaccine)
Date: _____
Vaccine type: _____
(Minimum interval is eight weeks)
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

PLEASE READ ENTIRE FORM CAREFULLY!

TUBERCULOSIS SCREENING QUESTIONNAIRE

(To be completed by ALL Students BEFORE registration at UL Lafayette)

THIS FORM CANNOT BE WAIVED!

UNIVERSITY of LOUISIANA LAFAYETTE

FAILURE TO COMPLETE THIS FORM AND SUBMIT TO STUDENT HEALTH SERVICES WILL RESULT IN AN IMMUNIZATION HOLD ON YOUR ACCOUNT AND WILL PREVENT YOU FROM REGISTERING FOR CLASSES

Student Health Services : P.O. Box 43692, Lafayette, LA 70504-3692 • Phone: 337-482-1293 • Fax: 337-482-1872 • Email: immunizations@louisiana.edu

Name : _____ **DOB:** _____ **ULID:** _____

ABOUT THIS FORM:

- UL Lafayette requires **ALL enrolled students** complete the Tuberculosis Screening Questionnaire that assesses the risk of TB infection and disease. This aids in the prevention and control of Tuberculosis on campus.
- If your Tuberculosis Screening Questionnaire is POSITIVE (answering YES to any of the questions below), further testing is required. This can be a lengthy process. To avoid delays in receiving your I-20 and/or being able to enroll in your preferred classes, complete this screening as soon as you are able.
- Answer the questions on this screening completely and accurately. Misrepresentation of information could jeopardize your health and the health of others.
- If you are under 18 or if you are unsure how to complete the questionnaire, a parent or guardian may be able to assist you.

*Please answer **YES** or **NO** to the following questions:*

1. Have you ever had close contact with persons known or suspected to have active Tuberculosis disease? □ Yes □ No

2. Were you born in one of the countries or territories listed BELOW that have a high incidence of active TB disease? □ Yes □ No

If **YES**, please **CIRCLE** the country below.

Angola	Cambodia	Ethiopia	Kenya	Moldova	Papua New Guinea	South Africa	Ukraine
Azerbaijan	Cameroon	Ghana	Korea	Mozambique	Peru	Swaziland	Uzbekistan
Bangladesh	Central African Republic	Guinea-Bissau	Kyrgyzstan	Myanmar	Philippines	Tajikistan	Viet Nam
Belarus	Chad	India	Lesotho	Namibia	Russian Federation	Tanzania	Zambia
Botswana	China	Indonesia	Liberia	Nigeria	Sierra Leone	Thailand	Zimbabwe
Brazil	Congo	Kazakhstan	Malawi	Pakistan	Somalia	Uganda	

3. In the last 5 years, have you visited one or more of the countries or territories listed above with a high prevalence of TB disease? (If YES, please CHECK the countries or territories, above) □ Yes □ No

4. Have you been a resident and/or employee of high risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? □ Yes □ No

5. Have you been a volunteer or health care worker who served clients who are at increased risk of active TB disease? □ Yes □ No

6. Have you ever been a member of any of the following groups that may have an increased incidence in latent M. tuberculosis infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol? □ Yes □ No

Source: World Health Organization Global Health observatory, Tuberculosis Incidence 2019. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to : http://www.who.int/tb/country/en/. UL Lafayette follows the screening guidelines of the American College Health Association (www.acha.org) and the US Center for Disease Control (www.cdc.gov/tb/publications/factsheets/default.htm).

If the answer to **ALL** of the above questions is **NO**, no further testing or action is required except to turn form in to SHS.

If the answer is **YES** to ANY of the questions above, you will be required to undergo further evaluation including a TB Skin Test (TST/PPD) or blood test prior to beginning class. Have your health care provider complete the attached TB Risk Assessment and testing form and return it to Student Health Services. (Documentation of a negative TB Test obtained in the past year may be accepted.) Appropriate documentation includes:

1. PPD (Mantoux) Skin test read and documented in millimeters of induration or IGRA blood test results. Both must be within the last 12 months.
2. If you have received treatment for active TB disease, you will need to provide proper documentation of treatment to Student Health Services prior to attending class.

Turn completed form into Student Health Services by mail, via fax, in person, or email to: immunizations@louisiana.edu prior to the start of school. This questionnaire can also be answered electronically via the patient portal. Patient portal is accessable through ULINK using your ULID and password. Any detailed information about how to complete this form or, how to get follow up testing can be explained via email or at Student Health Services.

Tuberculosis Risk Assessment

*** To be completed by a Health Care Provider ***

FAILURE TO COMPLETE THIS FORM AND SUBMIT TO STUDENT HEALTH SERVICES WILL RESULT IN AN IMMUNIZATION HOLD ON YOUR ACCOUNT AND WILL PREVENT YOU FROM REGISTERING FOR CLASSES.

Student Health Services: P.O. Box 43692, Lafayette, LA 70504-3692 • Phone: 337-482-1293 • Fax: 337-482-1872

Name: _____ **DOB:** _____ **Date:** _____

1. Does the student have signs or symptoms of active tuberculosis disease? **Yes or No**

   If **Yes**, proceed with additional evaluation to exclude active TB and/or seek appropriate treatment.
   If **No**, proceed to options 2 or 3 listed below.

2. **Tuberculin Skin Test (TST)** – TST recorded as actual millimeters of induration. Recommended interpretation below. Base results on risk factors.

Date given: ____/____/____ **LFA / RFA**
Date read: ____/____/____
Results: _____**mm induration**

Health Care Provider signature: _____
Health Care Provider signature: _____
Interpretation: Positive or Negative

TST interpretation guidelines:

>5 mm is positive:

- Recent close contacts of an individual with infectious TB
- Persons with fibrotic changes on a prior chest x-ray, consistent with past TB disease
- Organ transplant recipients and other immunosuppressed persons (including receiving equivalent of >15 mg/d of prednisone for >1 month.)
- HIV-infected persons

>10 mm is positive:

- Recent arrivals to the U.S. (< 5 years) from high prevalence areas or who resided in one for a significant amount of time
- Injection drug users
- Mycobacteriology laboratory personnel
- Residents, employees, or volunteers in high-risk congregation settings
- Persons with medical conditions that increase the risk of progression to TB disease including scoliosis, diabetes mellitus, chronic renal failure, certain types of cancer (leukemias and lymphomas, cancers of the head, neck or lung), gastrectomy or jejunoileal bypass and weight loss at least 10% below ideal body weight.

>15 mm is positive:

- Persons with no known risk factors for TB, except for testing programs required by law/regulations, who would not otherwise be tested.

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3. **Interferon Gamma Release Assay (IGRA)** – *recommended If previous TST positive*

Date obtained: _____ **Circle specific test: QuantiFERON-Gold T-SPOT**
Results: Positive or Negative

**Must provide copy of lab result or verified lab result on official letterhead or government issued document*.

IF TST AND IGRA TEST COME BACK POSITIVE, STUDENT WILL BE REFERRED TO LAFAYETTE PUBLIC HEALTH UNIT FOR MEDICAL EVALUATION AND CHEST X-RAY. A letter of clearance is needed prior to start of class.

Printed name of clinical personnel evaluating student: _____

Signature of evaluating healthcare provider: _____ **Date:** _____

Fax form and documents to (337)482-1872 or scan and email to immunizations@louisiana.edu prior to starting semester at UL Lafayette.

Medical office stamp required here: