For Office use

Initials

Louisiana Tech University

Student Health Center

P.O. Box 3023
Ruston, LA 71272
Phone: (318)257-4866
Fax: (318)257-3927
Email: health@latech.edu

MEDICAL HISTORY

Student Information (Please Print)

All information is confidential and is reviewed by Health Center Personnel only.

Name_____
(Last) (First) (Middle)

Social Security # or Student ID: _____ Date of birth _____/_____/_____ Age _____ Sex _____

Address_____
(Street) (City) (State) (Zip Code)

Telephone: (____) _____Cell: (_____) _____ Email:_____

Emergency Contact Information

Name: _____ Relationship: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Family History

Has any member of your family ever had any of the following? (Please check)

___Asthma or Hay Fever	___Cancer	___Convulsions/Seizures	___Diabetes
___Heart Disease	___High Blood Pressure	___Kidney Disease	___Mental Illness
___Rheumatism(arthritis)	___Sickle Cell	___Stomach, Intestinal Trouble	___Tuberculosis

Personal History

List any surgeries: _____

List any medical conditions you are currently being treated for:_____

List any medications you take on a regular basis:_____

List any serious illnesses: _____

List any food or drug allergies: _____

Comments: _____

_____

Insurance

Type	Company
Accident and Hospitalization	

PROOF OF IMMUNIZATION COMPLIANCE

UNIVERSITY REQUIRED IMMUNIZATIONS:

Physician or Other Health Care Provider Verification or Universal Certificate of Immunizations attached:

MMR (Measles, mumps, rubella – 2 doses required)		**Td or Tdap**
First dose: _____ (Date) Second dose: _____ (Date)	**OR** Serologic Test: _____ (Date) Result: _____ **OR** _____ Born before 1957	Td: _____ (Date within 10yrs) **OR** Tdap: _____ (Date within 10yrs)
Meningococcal Vaccine (One dose must be received on or after 16th birthday) Vaccine Type: _____ Date: _____		
_____ _____ **(Signature of Physician or other health care provider)** **(Date)**		**OFFICE STAMP REQUIRED**

UNIVERSITY RECOMMENDED IMMUNIZATIONS:

Physician or Other Health Care Provider Verification:

Hepatitis B Vaccine	**Varicella (chicken pox)**	
First dose: _____ (Date) Second dose: _____ (Date) Third dose: _____ (Date)	First dose: _____ (Date) Second dose: _____ (Date)	OR Disease: _____ (Date) OR Serologic Test: _____ Result: _____ (Date)
	Varicella (either a history of chicken pox, a positive Varicella antibody or two doses of a vaccine given at least one month apart if immunized after 13 years, meet the requirement.	

Please read the following information carefully:

Louisiana Law (R.S. 17:170/R.S. 17:170.1/Schools of Higher Learning) requires all students entering Louisiana Tech University to be immunized for the following: Measles, Mumps, Rubella (2 doses) for those born on or after January 1, 1957; Tetanus-Diphtheria (within the past 10 years); and against Meningococcal disease (Meningitis). The following guidelines presented are for the purpose of implementing the requirements of Louisiana R.S. 17:170.1, and of meeting the established recommendations for control of vaccine-preventable diseases as recommended by the American Academy of Pediatrics (AAP); the Advisory Committee on Immunization Practices to the United States Public Health Service (ACIP); and the American College Health Association (ACHA). Students not meeting these requirements will be prevented from registering for subsequent quarters.

Louisiana Tech University adheres to the equal opportunity provisions of federal and civil rights laws, and does not discriminate on the basis of race, color, national origin, religion, age, sex, sexual orientation, marital status or disability.

Request for Exemption – MMR and/or Meningitis

____Medical Reasons (Physician's statement in space provided) ____Personal Reasons

_____

_____

I fully understand that if I claim exemption for medical or personal reasons, I may be excluded from campus and 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.

_____ _____ **OR** _____ _____

Student Signature Date Physician Signature for Medical Exemption Date

Revised: 8/13

Name: _____ Social Security Number: _____

TUBERCULOSIS QUESTIONNAIRE
(MANDATORY – NO EXEMPTIONS)

The Student Health Center is evaluating all entering students for exposure to tuberculosis (TB). Please review and complete the information below **even if you have received a BCG (TB) vaccination in the past.** If you have any questions, please contact the Student Health Center at (318) 257-4866.

Have you ever had a positive PPD skin test in the past? **If yes, STOP. Please provide evidence of treatment and chest x-ray results.**	**YES** ____	**NO** ____

PAST HISTORY

	YES	**NO**
1. Were you born in, have you ever lived in, or recently traveled to (within the past 5 years) any country in the following areas of the world? (Excluding cruises) *Africa, Asia, Caribbean nations, Central America (including Mexico), Eastern Europe, India and other Indian Subcontinent Nations, Middle East, Portugal, South America, South Pacific (except Australia and New Zealand), or Spain*	_____	_____
2. Do you have a history of cancer, leukemia, kidney disease, diabetes, alcoholism, or intravenous drug use?	_____	_____
3. Have you resided, worked or volunteered in a prison, homeless shelter, hospital, nursing home, or other long-term treatment facility?	_____	_____
4. Do you have AIDS/HIV or take immunosuppressive medication such as prednisone?	_____	_____
5. Have you been in close contact with someone with TB?	_____	_____

IMPORTANT: If you answered "YES" to any of the above 5 questions listed under PAST HISTORY, you are required to have had a PPD skin test within the past year. You can obtain the PPD skin test from your physician or student health center. If you answered NO to all of the above, no further action is required.

NOTE TO HEALTH CARE PROVIDERS: Please record the size of the induration in millimeters. If there is no reaction, please record as "0 mm". **Students who have had a BCG vaccine are still required to have a PPD skin test**. If the screening skin test is positive (10mm or greater for those who answer "YES" to questions 1, 2, or 3, and 5mm or greater for those who answer "YES" to questions 4 or 5), we require an appointment at the public health clinic or please provide a copy of treatment and chest x-ray result. **You will not be allowed to attend classes until you have been seen by Lincoln Parish Health Unit TB division or until you provide documentation of previous treatment and chest x-ray result.**

Date PPD Applied: _____ Date PPD Read: _____ Size of Induration: _____mm Site of PPD: _____

Health Care Provider's Name: _____ Health Care Provider's Signature: _____

Referred to Public Health Unit: Yes _____ No _____ Appointment Date: _____

RETURN THIS FORM TO:

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