IMPORTANT INFORMATION

FROM: Angela McLean, M.D.
Director of Student Health Services

TO: All Entering Students of LSU Health Sciences Center

Congratulations on your acceptance. We are eagerly anticipating your arrival at LSUHSC and your addition to the LSUHSC family.

Your health forms include medical history information, physical examination, mandatory tests and immunization information. A completed health form is a mandatory component of the registration process. Your health care provider should perform all examinations, immunizations, laboratory tests and supporting documents as required. Please make a copy of all records before submitting.

All completed forms and supporting documents must be returned to the LSUHSC student health services no later than three (3) weeks prior to registration.

WARNING: Due to the large volume of health forms and records being received by Student Health during registration periods, neither Student Health nor Student Affairs offices can verify whether your health care provider actually mailed or faxed materials to Student Health.

Because all student health records are confidential, only Student Health Services staff maintains them. Therefore, should you have any questions regarding your file; you may contact the office.

*Especially important is proof of immunity to Hepatitis B or documentation that the Hepatitis B vaccine double or triple series has begun (1st immunization) and is current prior to registration. Specifically, the 2nd immunization must be given 30 days following the 1st immunization and the 3rd immunization must be 6 months following the first immunization. If the 2nd or 3rd immunization is due before registration, you must show proof of them to avoid a block.

Once you are a registered LSUHSC student, the remaining Hepatitis immunizations as well as yearly updates of Tuberculin skin tests can be performed by Student Health Services for a fee. It will be your responsibility to “mark your calendar” for future immunizations/test dates. Once again, it is conceivable that you could be blocked from registering, final grade reports, transcripts, or graduation materials if your health record in not kept current.

Again, welcome aboard and we look forward to serving you.

Please keep a copy of all records.

Revised 04/20/2015
STUDENT HEALTH SERVICES
LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER
2020 GRAVIER STREET
NEW ORLEANS, LOUISIANA 70112

FULL AND PRECISE INFORMATION IS A REQUIREMENT FOR REGISTRATION. EACH QUESTION MUST BE ANSWERED. INCOMPLETE RECORDS ARE NOT ACCEPTED.

PRINT OR TYPE ALL INFORMATION

MEDICAL HISTORY: Students are to complete this section very carefully. In the event of a medical emergency such information will be valuable. Your report will be available only to Student Health Services and appropriate administrative officers of the school.

Name (in full) ____________________________________________
Last First Middle or Maiden

Address ____________________________________________________________ Telephone ( ) _______ - _________
Birthdate__________ Marital Status__________________ Sex__________ Social Security No.; _______ - - - - - - - - - - - - - -

PERSON TO BE NOTIFIED IN THE EVENT OF SERIOUS ACCIDENT OR ILLNESS:

Name (in full) ____________________________________________ Relationship________________
Address ____________________________________________________________ Telephone ( ) _______ - _________
Office Address ____________________________________________________________ Telephone ( ) _______ - _________

YOUR FAMILY PHYSICIAN

Name__________________________________________________________ Office Telephone ( ) _______ - _________
Office Address__________________________________________________________

History □ Heart Disease □ Hypertension □ Diabetes □ Kidney Disease □ Emotional Problems
□ Communicable Diseases □ Illnesses □ Injuries □ Operations □ ADD/ADHD
Specify _________________________________________________________

Are you allergic to any medications, drugs, or foods? (Specify)
__________________________________________________________________________________________________________________

Medications taken regularly _________________________________________
Do you use (Yes or No) Alcohol _______ Tobacco _______ Drugs _______
Do you have any disabilities _______ Explain _________________________
Do you use any of the following? □ Yes □ No If yes, check appropriately and explain. Hearing Aid __________
Wheelchair __________________________ Eyeglasses, contact lens __________ Crutches __________
Artificial limb or eye _____________________________________________ Braces: extremity or back __________________
Do you have Health or Accident Insurance? □ Yes □ No If yes, identify the Insurance Company:

Name of Company ____________________________________________ Company Address ____________ Policy No. ____________
Date ____________ Student’s Signature ____________________________

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.
Date ____________ Student’s Signature ____________________________
MEDICAL EXAMINATION

(To be completed by physician not more than 90 days before registration)

Height ___________ Weight ___________ Blood pressure (sitting) _____________ Pulse (sitting) ___________ Resp ___________

CHECK EACH ON THE APPROPRIATE COLUMN:

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<th>NORMAL</th>
<th>ABNORMAL</th>
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TEST AND IMMUNIZATIONS

Dates of immunizations must be specified and reports of all labs and titers must be attached.

The following blood tests are **MANDATORY**

1. **Varicella Titer**
   - Date __________________________ Titer __________________________ Varivax 1 Date ____________
   - Varivax 2 Date ____________

   The following requirements must be satisfied by titers AND documentation of two (2) MMR immunizations (after age 1 year). If titers are low or negative; must show proof of two vaccines and a booster. If record of two MMR vaccines is unavailable, the positive titers are sufficient.

2. **Measles Titer**
   - Date __________________________ Titer __________________________ MMR #1 Date ____________

3. **Mumps Titer**
   - Date __________________________ Titer __________________________ MMR #2 Date ____________

4. **Rubella Titer**
   - Date __________________________ Titer __________________________ MMR #3 Date ____________
   - Booster

   **If Titers are negative, you must show proof of vaccines and also proof of a booster.**

The dates of each of the following must be specified

5. **Tetanus/Diphtheria with Pertussis (within 10 years)**
   - Date __________________________

6. **Hepatitis B vaccine dates**
   - 1st __________________________ 2nd __________________________
   - 3rd __________________________
   - Hepatitis B Surface AB Titer __________________________ (Required)

7. **Tuberculin Skin Test (within 1 year)**
   - Date __________________________ Result ____________

8. If the Tuberculin Skin Test is known to be positive, a chest x-ray is required within the past 6 months.
   - Date __________________________ Result ____________

9. **T-Spot or Quantiferon Gold**
   - Date __________________________ Result ____________

10. **Meningitis Vaccine #1**
    - Date __________________________ Meningitis Vaccine #2 Date __________________________
    (If before age 16)

11. **Flu Vaccine**
    - Date __________________________ (Only during Flu Season)

If for some reasons this student is unable to take immunizations, please explain. ________________________________________________________________

**SUMMARY OF PHYSICAL EXAMINATION**

Physician’s name (please print) __________________________________________________________

Address __________________________________________ Telephone (      ) ______

Physician’s signature __________________________ Date of Examination __________________________

**PLEASE RETURN COMPLETED FORM TO:**
LSUHSC Student Health Services
Attn: Phyllis P. Johnston
2020 Gravier Street, Room 716
New Orleans, LA 70112