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.

*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 03/07/2016
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.

<table>
<thead>
<tr>
<th>Name (in full)</th>
<th>Middle or Maiden</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last</td>
<td>First</td>
</tr>
<tr>
<td>Address</td>
<td>Telephone ( )</td>
</tr>
<tr>
<td>Birthdate</td>
<td>Marital Status</td>
</tr>
<tr>
<td>Sex</td>
<td>Social Security No.:</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Name (in full)</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>Telephone ( )</td>
</tr>
<tr>
<td>Office Address</td>
<td>Telephone ( )</td>
</tr>
</tbody>
</table>

YOUR FAMILY PHYSICIAN

<table>
<thead>
<tr>
<th>Name</th>
<th>Office Telephone ( )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Address</td>
<td></td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Name of Company</th>
<th>Company Address</th>
<th>Policy No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Student’s Signature</td>
<td></td>
</tr>
</tbody>
</table>

MEDICAL CONSENT--IMPORTANT

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

Local Physician’s Name

<table>
<thead>
<tr>
<th>Address</th>
<th>Office Telephone ( )</th>
</tr>
</thead>
</table>

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.
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:

<table>
<thead>
<tr>
<th></th>
<th>NORMAL</th>
<th>ABNORMAL</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head, Face, Scalp, Skin</td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Neck, Nodes, Thyroid</td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Eyes, Ears, Nose, Sinuses</td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Mouth and Teeth</td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Pharynx and Tonsils</td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Lungs and Chest</td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Breast</td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Abdomen, Hernia, Scars</td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Genitalia and Rectum (if indicated)</td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Extremities</td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Spine and Musculoskeletal</td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
<tr>
<td>Neurological Reflexes</td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
</tbody>
</table>
### 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 ________________

**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**
   - 1<sup>st</sup> ______________________
   - 2<sup>nd</sup> ______________________
   - 3<sup>rd</sup> ______________________
   - 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
POSITIVE PPD SCREENING
(This form should be completed by your health care provider)

Name of applicant: _____________________________________ Date: ______________

Date: ____________________________ PPD Result: _____________ mm

If PPD positive, document:

1) Date of positive PPD testing: _____________________________________

2) Treatment: _________________________ Dates: __________________________

3) Chest X-Ray: _____________ Dates: _____________

Results within past 12 months

Screening Practitioner’s Name (Print) Date

Screening Practitioner’s Signature

Are you currently experiencing any of the following symptoms?

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Cough</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Recent Weight Loss</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Hemoptysis</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Applicant’s Signature