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
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 __________________________ 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 _______

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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