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.

**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 you’re 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 discounted 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.

Revised 05/28/14
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) __________________________________________________________

Address __________________________________________________________________

Birthdate ________________ Marital Status ________________ Sex ________________ Social Security No.: ________________ - - - - - - - - -

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

Name (in full) __________________________________________________________

Address __________________________________________________________________

Office Address __________________________________________________________________

YOUR FAMILY PHYSICIAN

Name __________________________________________________________

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>CHECK</th>
<th>NORMAL</th>
<th>ABNORMAL</th>
<th>COMMENTS</th>
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<td>Eyes, Ears, Nose, Sinuses</td>
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<td>Genitalia and Rectum (if indicated)</td>
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<td>Neurological Reflexes</td>
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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 may be satisfied by titers OR documentation of two (2) MMR immunizations (after age 1 year)

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 Titors are low, you will need 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\(^{st}\) ___________________  2\(^{nd}\) ___________________
   3\(^{rd}\) ___________________

   OR Hepatitis B Surface AB Titer ___________________

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 ___________________

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

Revised 4/8/13
REFUSAL OF VACCINATION AND RELEASE FROM RESPONSIBILITY

BE IT KNOWN that on this date, I, _________________________________________

(Name of Student)

have decided voluntarily to disregard the medical advice of the qualified health professionals attending me on behalf of
the University and the Louisiana Department of Health and Hospitals.

I AM REFUSING TO RECEIVE VACCINATION AGAINST MENINGITIS.

I HAVE BEEN FULLY INFORMED BY READING THE CENTERS FOR DISEASE CONTROL AND
PREVENTION MENINGITIS VACCINE INFORMATION STATEMENT.

and understand the possible and probable adverse consequences of my refusal. I understand that my health could be
negatively affected and my possibly endangered by this refusal. The reason for my refusal is

________________________________________________________________________

I declare myself to be a person of the full age of majority and to be mentally competent. I hereby assume full
responsibility for any and all possible present or future results or complications of my condition due to this refusal.

I do further hereby now and forever free and release the University and the Department of Health and Hospitals and all
its agents, attending health care professionals, and other personnel from any and all legal or financial responsibility as a
result of this refusal.

I certify that I have read (or had read to me) and that I fully understand this Refusal of Treatment and Release from
Responsibility. All explanations were made to me and all blanks filled in before I signed my name. I have refused this
vaccination of my own free will.

_________________________ am/pm
Month   Day   Year

Printed Name  Signature