VISITING STUDENT IMMUNIZATION REQUIREMENTS

All visiting students are required to have the attached 3-page health immunization form completed and returned with your application packet as part of the requirement for applying for a clerkship with LSU Health Shreveport. The following immunization requirements are required:

- Varicella Titer (chicken pox)
- Rubella Titer
- Current Tetanus Vaccine
- Dates of Polio Vaccine
- Two dates of MMR (if born after 1957)
- Hepatitis B Vaccine (first two doses are required prior to beginning the rotation)
- Current TB skin test taken within the current calendar year, date given and read. (must be given at least 48 to 72 hours prior to beginning the rotation) Results must be recorded in millimeters. Indicate name of person who read test and their title. If results are positive, need results recorded in millimeters, date treatment began and ended. Chest X Ray must be completed within the last six months, day taken and results.
- Due to a new LSU hospital policy, all students and employees must have an annual flu vaccination, or if declined, must wear a mask while in patient care areas during flu season (November through April). If you are accepted for a rotation from November through April, you are required to show proof that you received this vaccination.
- Meningococcal Vaccine is required unless a waiver is signed stating the student has received and reviewed Meningococcal Vaccine information and has chosen not to be vaccinated for religious or other personal reasons. Physician documentations of contraindications for vaccine is also accepted.

Please do not send your individual health records. Use the three page health form attached to provide the required health information.

If you have any questions regarding the health form, please contact Occupational Health directly at (318) 675-6282. The Office of the Registrar cannot assist you with any questions you may have in regard to the immunization requirements.
LSU Health Shreveport
Occupational Health Clinic

Student Health Program

Full and precise information is a requirement for registration. Each question must be answered. Incomplete records are NOT accepted.

-PRI NT OR TYPE ALL INFORMATION-

Name (in full): ____________________________

Address: ____________________________

Birthdate: __________

Marital Status: ______

Gender: ______

Social Security No.: ______

Telephone: ( )

Office Address: ____________________________

Office Telephone: ____________________________

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

Name (in full): ____________________________

Address: ____________________________

Office Address: ____________________________

Office Telephone: ____________________________

Relationship: ____________________________

Telephone: ____________________________

YOUR FAMILY PHYSICIAN

Name: ____________________________

Telephone: ____________________________

Office Address: ____________________________

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 the Student Health Service and appropriate administrative officers of the school. If none apply, check the box so labeled.

History of: □ Heart Disease □ Hypertension □ Diabetes □ Kidney Disease □ Emotional Problems

□ Communicable Diseases □ Illnesses □ Injuries □ Operations □ None

Specify: ____________________________________________

Are you allergic to any medications, drugs, or foods? □ Yes □ No If yes, specify: ____________________________

Medicines taken regularly:

Do you use – Alcohol: □ Yes □ No Tobacco: □ Yes □ No Drugs: □ Yes □ No

Do you have any disabilities: □ Yes □ No If yes, explain: ____________________________

If you use any of the following, please check and explain: □ Hearing Aid □ Wheelchair □ Eyeglasses / Contact Lenses

□ Crutches □ Artificial Limb or Eye □ Braces, extremity or back □ Other ____________________________

MEDICAL INSURANCE

Company: ____________________________

Company Address: ____________________________

Policy Number: ____________________________

Date: ____________________________

Student’s Signature: ____________________________

MEDICAL CONSENT - IMPORTANT!

In case of 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: ____________________________
Student Health Service

Student: ____________________________________________________________

School: ___________________________ Entrance Date: ______________________

PHYSICIAN’S STATEMENT

Medical History

Does this student have a significant history of disease in the following systems:

<table>
<thead>
<tr>
<th>System</th>
<th>Yes</th>
<th>No</th>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dermatologic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endocrine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes, Ears, Nose, Sinuses</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Pulmonary</td>
<td></td>
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<tr>
<td>Cardiac</td>
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<tr>
<td>Gastroenterology</td>
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<tr>
<td>Genitourinary</td>
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<tr>
<td>Neurologic</td>
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<td></td>
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<tr>
<td>Extremities, Musculoskeletal</td>
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<td></td>
<td></td>
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<tr>
<td>Surgeries</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergies (drugs, foods, etc.)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Has this student any chronic illness? If yes, explain

Is this student on any medications (insulin, phenytoin, allergy injection, etc)? □ Yes □ No
If yes, drug(s) name, dosage, etc.

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

Physical Examination

Height: _______  Weight: _______  Blood Pressure (Sitting): _______  Pulse (Sitting): _______  Resp.: _______

<table>
<thead>
<tr>
<th>Body Part</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>
<tr>
<td>Other</td>
<td>□</td>
<td>□</td>
<td></td>
</tr>
</tbody>
</table>

Physician’s Printed Name: ___________________________ Signature: ___________________________ Date: ___________________________
Tests and Immunizations for Visiting Students
Dates of Immunizations MUST BE Specified

The following blood tests are MANDATORY:

1. Varicella Titer: Date: ___________ Results: ☐ Positive ☐ Negative
2. Rubella Titer Date: ___________ Results: ☐ Positive ☐ Negative

REQUIRED Immunizations:

3. Tetanus /Diphtheria/Pertussis (TDap) (within 10 years) – Date: ___________
4. Poliomyelitis Vaccine: Date series completed or date of last booster: ___________
5. MMR Vaccines or Titer: (Dates)
   MMR #1: Date: _________ OR Measles Titer: Date: ___________ ☐ Positive ☐ Negative
   MMR #2: Date: ___________ OR Mumps Titer: Date: ___________ ☐ Positive ☐ Negative
6. Hepatitis B Vaccine: (Doses #1 & 2 are required before registration)
   Hep B Vaccine #1 - Date: ___________ Dose #2 - Date: ___________ Dose #3 - Date: ___________
   Hep Bs-antibody titer* - Date: ___________ ☐ Positive ☐ Negative
   *HBs-Ab should be done only if you have completed the Hepatitis B vaccine series AND 30 days or more have passed since completing the series OR you have had Hepatitis B disease.
7. Tuberculin Skin Test (PPD Mantoux Test ONLY. Must be current within the calendar year.)
   Date Applied: ___________ Date Read: _________ Results: _______ (mm)
   For a positive TB skin test, a chest X-ray is required within the last 6 months. Date: _________ Results: _______
   If treated prophylactically for positive TB skin test: ______ Date treatment began: ______ Date treatment completed
8. Influenza vaccination required for attending rotations during months of November through April. Date received: _______
9. Meningococcal Vaccine (required unless waiver is signed) Date: ___________
   Please provide explanation for student’s inability to take a particular immunization:

__________________________________________________________________________________________

__________________________________________________________________________________________

Physician’s Name: ___________________________ Date: _______________

Address: ___________________________________________
          ___________________________________________
          ___________________________________________

Office Telephone: (____) ___________________________

Physician’s Signature: ____________________________

Please return completed form to: LSUHSC - Registrar
    Attn: Sandra Ward
    1501 Kings Highway / P.O. Box 33932
    Shreveport, LA 71130-3932
**What is meningococcal disease?**

Meningococcal disease is a serious illness, caused by a bacteria. It is a leading cause of bacterial meningitis in children 2-18 years old in the United States.

Meningitis is an infection of fluid surrounding the brain and the spinal cord. Meningococcal disease also causes blood infections.

About 2,600 people get meningococcal disease each year in the U.S. 10-15% of these people die, in spite of treatment with antibiotics. Of those who live, another 11-19% lose their arms or legs, become deaf, have problems with their nervous systems, become mentally retarded, or suffer seizures or strokes.

Anyone can get meningococcal disease. But it is most common in infants less than one year of age and people with certain medical conditions, such as lack of a spleen. College freshmen who live in dormitories have an increased risk of getting meningococcal disease.

Meningococcal infections can be treated with drugs such as penicillin. Still, about 1 out of every ten people who get the disease dies from it, and many others are affected for life. This is why preventing the disease through use of meningococcal vaccine is important for people at highest risk.

**Meningococcal vaccine**

Two meningococcal vaccines are available in the U.S.:

- **Meningococcal polysaccharide vaccine (MPSV4)** has been available since the 1970s.
- **Meningococcal conjugate vaccine (MCV4)** was licensed in 2005.

Both vaccines can prevent 4 types of meningococcal disease, including 2 of the 3 types most common in the United States and a type that causes epidemics in Africa. Meningococcal vaccines cannot prevent all types of the disease. But they do protect many people who might become sick if they didn’t get the vaccine.

Both vaccines work well, and protect about 90% of those who get it. MCV4 is expected to give better, longer-lasting protection.

MCV4 should also be better at preventing the disease from spreading from person to person.

**Who should get meningococcal vaccine and when?**

MCV4 is recommended for all children at their routine preadolescent visit (11-12 years of age). For those who have never gotten MCV4 previously, a dose is recommended at high school entry.

Other adolescents who want to decrease their risk of meningococcal disease can also get the vaccine.

Meningococcal vaccine is also recommended for other people at increased risk for meningococcal disease:

- College freshmen living in dormitories.
- Microbiologists who are routinely exposed to meningococcal bacteria.
- U.S. military recruits.
- Anyone traveling to, or living in, a part of the world where meningococcal disease is common, such as parts of Africa.
- Anyone who has a damaged spleen, or whose spleen has been removed.
- Anyone who has terminal complement component deficiency (an immune system disorder).
- People who might have been exposed to meningitis during an outbreak.

MCV4 is the preferred vaccine for people 11-55 years of age in these risk groups, but MPSV4 can be used if MCV4 is not available. MPSV4 should be used for children 2-10 years old, and adults over 55, who are at risk.
How Many Doses?
People 2 years of age and older should get 1 dose. (Sometimes an additional dose is recommended for people who remain at high risk. Ask your provider.)

MPSV4 may be recommended for children 3 months to 2 years of age under special circumstances. These children should get 2 doses, 3 months apart.

Some people should not get meningococcal vaccine or should wait

- Anyone who has ever had a severe (life-threatening) allergic reaction to a previous dose of either meningococcal vaccine should not get another dose.
- Anyone who has a severe (life threatening) allergy to any vaccine component should not get the vaccine. Tell your doctor if you have any severe allergies.
- Anyone who is moderately or severely ill at the time the shot is scheduled should probably wait until they recover.
- Ask your doctor or nurse. People with a mild illness can usually get the vaccine.
- Anyone who has ever had Guillain-Barre Syndrome should talk with their doctor before getting MCV4.
- Meningococcal vaccines may be given to pregnant women. However, MCV4 is a new vaccine and has not been studied in pregnant women as much as MPSV4 has. It should be used only if clearly needed.
- Meningococcal vaccines may be given at the same time as other vaccines.

What are the risks from meningococcal vaccines?
A vaccine, like any medicine, could possibly cause serious problems, such as severe allergic reactions. The risk of meningococcal vaccine causing serious harm, or death, is extremely small.

Mild problems
Up to about half of people who get meningococcal vaccines have mild side effects, such as redness or pain where the shot was given.

If these problems occur, they usually last for 1 or 2 days. They are more common after MCV4 than after MPSV4.

A small percentage of people who receive the vaccine develop a fever.

Severe problems
- Serious allergic reactions, within a few minutes to a few hours of the shot, are very rare.
- A few cases of Guillain-Barre Syndrome, a serious nervous system disorder, have been reported among people who got MCV4. There is not enough evidence yet to tell whether they were caused by the vaccine. This is being investigated by health officials.

What should I look for?
- Any unusual condition, such as a high fever or behavior changes. Signs of a serious allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heart beat or dizziness.

What should I do?
- Call a doctor, or get the person to a doctor right away.
- Tell your doctor what happened, the date and time it happened, and when the vaccination was given.
- Ask your doctor, nurse, or health department to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form.

Or you can file this report through the VAERS web site at www.vaers.org, or by calling 1-800-822-7967. VAERS does not provide medical advice.

How can I learn more?
- Ask your doctor or nurse. They can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call 1-800-232-4636 (1-800-CDC-INFO)
  - Visit CDC’s National Immunization Program website at www.cdc.gov/nip
  - Visit CDC’s meningococcal disease website at www.cdc.gov/ncidod/dbmd/diseaseinfo/ meningococcal_g.htm
  - Visit CDC’s Travelers’ Health website at www.cdc.gov/travel
Vaccine Refusal Form

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 life 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.

__________________________  ____________________________
Month      Day      Year  Time

☐ AM  ☐ PM

Printed Name  Signature

If completing this waiver, please include this with the visiting student health form.