**PROOF OF IMMUNIZATION COMPLIANCE**

Please return the completed form to: University of Louisiana at Lafayette, Student Health Service: PO Box 43692, Lafayette, LA 70504-3692, Fax: 337-482-1873

Name: _______ (Last/Family) _______ (First/Given) Date of Birth: _______ CLID/SSN: _______

When do you plan to start at UL Lafayette: _______ Month _______ Year

Email: _______ Telephone: _______

**Instructions**: Immunization requirements are applicable ONLY to students born on or after January 1, 1957. Sections A (and/or B) & C must be completed. You must either have a physician or health care provider complete Section A or submit the Universal Certificate of Immunizations provided by the Department of Health and Hospitals, Office of Public Health. No other attachments or photocopies accepted. If you have not been immunized for all required diseases, you may request an exemption by completing Section B. However, Section C cannot be waived and must be completed.

**IMPORTANT**: Failure to complete AND turn in this form will PREVENT you from being able to schedule classes.

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### Section A: Documentation of Immunizations

**OR**

<table>
<thead>
<tr>
<th>Disease</th>
<th>Requirement</th>
<th>Dose 1 Date</th>
<th>Dose 2 Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMR (measles, mumps, rubella)</td>
<td>Two doses</td>
<td></td>
<td></td>
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<tr>
<td>AND</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TETANUS</td>
<td>One dose</td>
<td></td>
<td></td>
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<tr>
<td>AND</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningitis</td>
<td>Two doses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AND</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Physician or Health Care Provider Stamp Here**

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### Section B: Immunization Exemption Request

**Instructions**: Only complete Section B if you are choosing not to be vaccinated. Otherwise, please disregard.

I have chosen not to be vaccinated for and am requesting an exemption from one or more of the vaccination(s) listed in Section A: Documentation of Immunizations, and I am aware of the risks. Vaccination(s) for which I am requesting exemption:

Reason for Immunization Exemption Request (please check one):

- [ ] Medical
- [ ] Personal
- [ ] Shortage (unable to locate vaccine)
- [ ] Other: _______

I understand that if I claim an exemption for personal or medical reasons, I may be excluded from campus and from classes in the event of an outbreak of measles, mumps, rubella, or meningitis until the outbreak is over or until I submit proof of immunization. I have reviewed information regarding vaccine-preventable diseases and related vaccinations contained on the website for the Center for Disease Control and Prevention (CDC): [http://www.cdc.gov/vaccines/hcp/vac/index.html](http://www.cdc.gov/vaccines/hcp/vac/index.html). If I am not 18 years of age or older, my parent or legal guardian must also sign below.

Student Signature: _______ Date: _______ Parent Signature (for students under 18 years old): _______ Date: _______

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Revised 11/23/2015
TUBERCULOSIS SCREENING QUESTIONNAIRE

(To be completed by ALL Students BEFORE registration at UL Lafayette)

THIS FORM CANNOT BE WAIVED!

FAILURE TO COMPLETE THIS FORM AND SUBMIT TO STUDENT HEALTH SERVICES WILL RESULT IN AN IMMUNIZATION HOLD ON YOUR ACCOUNT AND WILL PREVENT YOU FROM REGISTERING FOR CLASSES.

Student Health Services: P.O. Box 43692, Lafayette, LA 70504-3692 • Phone: (337)482-1293 • Fax: (337)482-1872 • Email: immunizations@louisiana.edu

Name: ________________________  DOB: _______________  ULID: ________________________

ABOUT THIS FORM:
• UL Lafayette requires ALL enrolled students complete the Tuberculosis Screening Questionnaire that assesses the risk of TB infection and disease. This aids in the prevention and control of Tuberculosis on campus.
• If your Tuberculosis Screening Questionnaire is POSITIVE (answering YES to any of the questions below), further testing is required. This can be a lengthy process. To avoid delays in receiving your I-20 and/or being able to enroll in your preferred classes, complete this screening as soon as you are able.
• Answer the questions on this screening completely and accurately. Misrepresentation of information could jeopardize your health and the health of others.
• If you are under 18 or if you are unsure how to complete the questionnaire, a parent or guardian may be able to assist you.

Please answer YES or NO to the following questions:

1. Have you ever had close contact with persons known or suspected to have active Tuberculosis disease? □ Yes □ No

2. Were you born in one of the countries or territories listed BELOW that have a high incidence of active TB disease? □ Yes □ No
If YES, please CIRCLE the country below.

- Angola
- Cameroon
- Central African Republic
- Chad
- Colombia
- Congo
- Cuba
- Ethiopia
- Guinea-Bissau
- Kenya
- Korea
- Kyrgyzstan
- Lesotho
- Liberia
- Malawi
- Mali
- Maldives
- Moldova
- Mozambique
- Myanmar
- Namibia
- Nauru
- Nepal
- Netherlands
- New Zealand
- Nicaragua
- Niger
- Nigeria
- Pakistan
- Papua New Guinea
- Peru
- Russian Federation
- Rwanda
- Senegal
- Serbia
- Sierra Leone
- Somalia
- South Africa
- Swaziland
- Tajikistan
- Tanzania
- Thailand
- Trinidad and Tobago
- Tunisia
- Ukraine
- Uzbekistan
- Viet Nam
- Zambia
- Zimbabwe

3. In the last 5 years, have you visited one or more of the countries or territories listed above with a high prevalence of TB disease? (If YES, please CHECK the countries or territories, above) □ Yes □ No

4. Have you been a resident and/or employee of high risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? □ Yes □ No

5. Have you been a volunteer or health care worker who served clients who are at increased risk of active TB disease? □ Yes □ No

6. Have you ever been a member of any of the following groups that may have an increased incidence in latent Tuberculosis infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol? □ Yes □ No


If the answer to ALL of the above questions is NO, no further testing or action is required except to turn form in to SHS.

If the answer is YES to ANY of the questions above, you will be required to undergo further evaluation including a TB Skin Test (TST/PPD) or blood test prior to beginning class. Have your health care provider complete the attached TB Risk Assessment and testing form and return it to Student Health Services. (Documentation of a negative TB test obtained in the past year may be accepted.) Appropriate documentation includes:

1. PPD (Mantoux) Skin test read and documented in millimeters of induration or IGRA blood test results. Both must be within the last 12 months.
2. If you have received treatment for active TB disease, you will need to provide proper documentation of treatment to Student Health Services prior to attending class.

Turn completed forms to Student Health Services by mail, via fax, in person, or email to: immunizations@louisiana.edu prior to the start of school. This questionnaire can also be answered electronically via the patient portal. Patient portal is accessible through ULINK using your ULID and password. Any detailed information about how to complete this form or, how to get follow up testing can be explained via email: shs@louisiana.edu or by calling Student Health Services at: (337) 482-1293.