

Please return the completed form to: University of Louisiana at Lafayette; Graduate School:  
PO Box 44610, Lafayette, LA 70504-4610, Fax: 337-482-1873

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

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.

## Section A: Documentation of Immunizations

### 1. MMR (MEASLES, MUMPS, RUBELLA) (Two Doses Required)

Date of 1st dose: \_\_\_\_\_

Date of 2nd dose: \_\_\_\_\_

### AND

### 2. TETANUS (One Dose Required Within 10 years)

Date: \_\_\_\_\_

Vaccine type: \_\_\_\_\_

### AND

### 3. MENINGITIS (Two Doses of meningococcal vaccine)

Date: \_\_\_\_\_

Vaccine type: \_\_\_\_\_

(At least 30 days apart)

Date: \_\_\_\_\_

Vaccine type: \_\_\_\_\_

OR

### MEASLES (Two Doses Required)

Date of 1st dose: \_\_\_\_\_

Date of 2nd dose: \_\_\_\_\_

### MUMPS (At least One Dose Required)

Date: \_\_\_\_\_

### RUBELLA (At least One Dose Required)

Date: \_\_\_\_\_

Physician or Health Care Provider Stamp Here

Signature of Physician or Health Care Provider

Address

City, State, Zip

Date Telephone

## 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/vis/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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Country of Origin: \_\_\_\_\_ (Do NOT leave blank)

## Section C: Tuberculosis (TB) Screening and Targeted Testing

**Instructions:** Complete all questions in Section C, Part I.

- If the answer is **NO** to **ALL** questions, no further testing or action is required.
- If the answer is **YES** to any of the below questions, you are required to have your physician or health care provider complete Section C, Part II. You are required to have a tuberculin skin test (PPD). You may use record of a previous PPD skin test if it was within the last 12 months. PPD skin tests can be obtained from your physician or walk-in clinic.

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### Section C Part I: Tuberculosis (TB) Screening

1. Have you ever had close contact with persons known or suspected to have active TB disease?  yes  no
2. Were you born in, have you ever lived in, or recently traveled (within the past 5 years for 2 hours or more) to a high risk country?  yes  no  
Africa, Asia, Central America (including Mexico), Eastern Europe, India  
and other Indian Subcontinent Nations, Middle East, Portugal, South America,  
South Pacific (except Australia and New Zealand)
3. Have you ever had a BCG (Tuberculosis vaccination)? If yes, date/year: \_\_\_\_\_  yes  no

### Section C Part II: Tuberculosis (TB) Targeted Testing

**Instructions:** Section C, Part II to be completed only if there is a **YES** answer to any questions from Section C, Part I. Section C, Part II to be completed by physician or health care provider **ONLY**.

#### Clinical Assessment by HealthCare Provider

- Please review and verify the 3 questions from **Section C, Part I** completed by student.
- Persons answering YES to any of the questions in **Section C, Part I** are required to have a Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented.
- Refer to [www.cdc.gov](http://www.cdc.gov) for interpretation of TST results:
  - If TST is positive: IGRA is required
  - If IGRA is positive: refer to public health
- Results:
  - TST (results should be based on actual millimeters (mm) of induration; if none, write "0 mm")
    - Date applied: \_\_\_\_-\_\_\_\_-\_\_\_\_ Date read: \_\_\_\_-\_\_\_\_-\_\_\_\_
    - mm of induration: \_\_\_\_\_
  - IGRA
    - Date obtained: \_\_\_\_-\_\_\_\_-\_\_\_\_ Method: (circle or fill in blank) **QFT-GIT** or **T-Spot** or **Other** \_\_\_\_\_
    - Result: (circle one) **negative** or **positive** or **indeterminate** or **borderline** (T-Spot only)
- Assessment: (please check)
  - \_\_\_\_ TST is negative: no further action is required.
  - \_\_\_\_ TST is positive and IGRA is negative: no further action is required.
  - \_\_\_\_ TST is positive and IGRA is positive: refer to public health (please specify) \_\_\_\_\_

\*Please notify patient that a letter from public health must be received in order to gain clearance for entrance to campus.

\_\_\_\_\_  
Signature of Physician or Health Care Provider

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone

Physician or Health Care Provider Stamp Here