PROOF OF IMMUNIZATION COMPLIANCE

Louisiana R.S. 17:170/Schools of Higher Learning

For Applicant:

Last Name: ____________________ First Name: ________________________ MI: ________

DOB: __________________ Applicant Email: ____

Degree Applying for w/ Return Instructions:

☐ Leavell College ☐ Graduate Program ☐ Doctoral Program

Leavell College Admissions
3939 Gentilly Blvd
New Orleans, LA 70126
leavelladmissions@nobts.edu

NOBTS Admissions
3939 Gentilly Blvd
New Orleans, LA 70126
gradadmissions@nobts.edu

NOBTS ProDoc Admissions
3939 Gentilly Blvd
New Orleans, LA 70126
dmin@nobts.edu

NOBTS ReDoc Admissions
3939 Gentilly Blvd
New Orleans, LA 70126
phd@nobts.edu

Instructions: Complete the Proof of Immunization Compliance in three ways.

1 One, take this document to a physician and have them complete it.

2 Two, retrieve a copy of your immunizations which will suffice of completion.

3 Three, complete the exemption section and LDH form.

PLEASE RETURN TO ADMISSIONS OFFICE BY UPLOADING TO YOUR APPLICATION PORTAL OR EMAILING A COPY TO LISTED EMAILS ABOVE.

Measles (Rubeola)

The state of Louisiana requires proof of two measles vaccinations for students enrolling at Louisiana institutions of higher learning born after 01/1957.

Date of 1st Measles: ______________________

Date of 2nd Measles: ______________________

Date of Serologic Proof of Immunity: _________

*Must attach lab results of serologic proof

Tetanus-Diphtheria

Required within the past ten years.

Date of Immunization: ____________________

Please check: ☐ TD ☐ TDAP

Mumps and Rubella

The state of Louisiana requires proof of one vaccination against mumps and rubella for all new students enrolling at Louisiana institutions of higher learning born after 1/1/57.

Mumps

Date of Immunizaton: ________________________

Date of Serologic Proof of Immunity: ____________

Rubella (German measles)

Date of Immunization:________________________

Date of Serologic Proof of Immunity: ____________

*Must attach lab results of serologic proof

Meningitis:

The state of Louisiana requires proof of Meningococcal immunization for college freshman.

Last Dose:____________________

Vaccine Type: _________________

Place Clinic Stamp Below

Name of Health Care Provider: ______________________________ Address: _______________________________

Signature of Health Care Provider: ___________________________ Date: _________________________________

REQUEST FOR EXEMPTION FROM IMMUNIZATION

Please copy and paste this in a web browser, print and fill out form and upload to your application portal or send to your admissions counselor. ***Please put N/A for guardian if signing for yourself.**

https://ldh.la.gov/assets/oph/Center-PHCH/Center-PH/immunizations/statement-of-exemption-from-immunizations.pdf

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Tuberculosis Targeted Testing

Louisiana R.S. 17:170/Schools of Higher Learning

Last Name: ____________________ First Name: ____________________ MI: ________ Date of Birth: ____________________

Section One: Section One: Questionnaire

Please answer the following questions:	Yes	No
1. Have you traveled in the past 5 years or lived more than 6 weeks in Africa, East Europe, Asia, Middle East, or South/Central America?		
2. Do you have a personal history of cancer, leukemia, kidney disease, diabetes, alcoholism, or intravenous drug use? (Family history does not apply)		
3. Have you been a resident, employee, or volunteer in a prison, nursing home, homeless shelter, hospital, or long-term treatment facility?		
4. Have you ever been vaccinated with BCG Tuberculosis vaccination?		
5. Do you have AIDS/HIV or take medications that suppress the immune system such as prednisone?		
6. Have you ever had close contact with persons known or suspected to have active TB disease?		
7. Have you ever tested positive for TB?		

If the answer to all of the above questions is NO, sign below and return this document to the Professional Doctoral office.

Signature: ____ Date ____________________

If the answer is YES to any of the above questions, NOBTS requires results of TB testing within the past year.

A healthcare provider should complete section two of this form below.

Section Two: Test Results

Step 1: Tuberculin Skin Test--Positive if ≥ 10mm for questions 1, 2, 3, or 4 or ≥ 5mm for questions 5 or 6.

Date Given: ________ Date Read: ________ Result: _____mm of induration Interpretation: Positive____ Negative ____

Step 2: A QFT or T-SPOT is required if PPD is positive. A Chest X-Ray will not be accepted in its place. (Please provide a copy of results.) Date obtained: ________ Circle Method Given: QFT T-SPOT Result: Positive ____ Negative: ____

Step 3: Students with a positive QFT or T-SPOT should receive a Chest X-Ray.

Date of X-Ray: ________ Result: Normal ____ Abnormal: ____

Step 4: Students with a positive QFT or T-SPOT with no signs of active disease on chest X-Ray are recommended to be treated for Latent TB with appropriate medication.

Name of medication for treatment: ______________________________

Date initiated and duration of treatment: ______________________________

Please provide a copy of completion of treatment.

________ Student has been treated or agrees to receive treatment.

________ Student declines treatment at this time and agrees to routine checkups to monitor progression of Latent TB.

Name of Health Care Provider (Print): ____

Address: ____ Signature of Health Care Provider: ______________________________

Date: ____