Proof of Immunization Compliance

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

Last Name: _____ First Name: _____ MI: _____ Date of Birth: _____

Applicant Email: _____ Applicant Phone Number: _____

*If needed, the NOBTS and Leavell College Clinic can provide immunizations and screenings. Contact the clinic at 504.816.8596 with questions regarding services.

Return Instructions

For Applicants: 1. Check the box of the program you are pursuing.
2. If document is returned to you, either upload a scan/photo of the document to your application portal, or fax/mail.

For Health Care Providers: Please either return the form to the applicant, or fax/mail the completed form to the location selected by the applicant.

☐ Leavell College
Leavell College Admissions
P.O. Box 285
3939 Gentilly Blvd.
New Orleans, LA 70126
Fax: 504.816.8453

☐ Graduate Program
NOBTS Grad Admissions
P.O. Box 285
3939 Gentilly Blvd.
New Orleans, LA 70126
Fax: 504.816.8453

☐ Professional Doctorate
NOBTS ProDoc Admissions
P.O. Box 220
3939 Gentilly Blvd.
New Orleans, LA 70126
Fax: 504.816.8170

☐ Research Doctorate
NOBTS ReDoc Admissions
P.O. Box 286
3939 Gentilly Blvd.
New Orleans, LA 70126
Fax: 504.816.8039

Physician or Other Health Care Provider Verification

Measles (Rubeola)

The state of Louisiana requires proof of **two** measles vaccinations for students enrolling at Louisiana institutions of higher learning born after 1/1/57.

Date of 1st Immunization: _____/_____/_____

Date of 2nd Immunization: _____/_____/_____

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 Immunization: _____/_____/_____

Date of Serologic Proof of Immunity: _____/_____/_____
Must attach lab results of serologic proof

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 freshmen.

Last Dose: _____/_____/_____
Vaccine type: _____

Place Clinic Stamp Below

Name of Health Care Provider (Print): _____ Address: _____

Signature of Health Care Provider: _____ Date: _____

Request For Exemption from Immunization

If you request an immunization exemption for personal or medical reasons, please check the appropriate blank and provide the information requested.

☐ Medical (physician statement required)
☐ Personal (student or parent state reason in space provided)
☐ Shortage (unable to locate vaccine)

Statement from Physician, Student, or Parent (if applicant under 18):

_____

Signature: _____ Date: _____

I understand that if I claim exemption, I may be excluded from campus and from classes in the event of an outbreak of measles, mumps, or rubella until the outbreak is over or until I submit proof of immunization. I do further free and release NOBTS, its employees, and personnel from any and all legal and financial responsibility of this refusal.

Student's Signature _____ Date: _____

Parent/Legal Guardian Signature (if applicant under 18) _____ Date: _____

Tuberculosis Targeted Testing

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

Last Name: _____ First Name: _____ MI: _____ Date of Birth: _____

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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 appropriate admissions 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: _____