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:__________________________
   OR
   MEASLES
   (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:__________________________
   (Minimum interval is eight weeks)
   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. TB skin test cannot be waived.

   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 ______________________ Date ______________________
   (for students under 18 years old)

   Revised 11/23/2015
PROOF OF IMMUNIZATION COMPLIANCE

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

Please return the completed form to: University of Louisiana at Lafayette; Office of International Affairs:
PO Box 43932, Lafayette, LA 70504-3932

Name: _______________________________ Date of Birth: _______________ CLID/SSN: _______________

(Last/Family) (First/Given) (Do NOT leave blank)

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.

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

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?
   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)
   ☐ yes ☐ no

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 Health Care 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 for interpretation of TST results:
  o If TST is positive: IGRA is required
  o If IGRA is positive: refer to public health
• Results:
  o TST (results should be based on actual millimeters (mm) of induration; if none, write “0 mm”)
    • Date applied: ______-____-____ Date read: ______-____-____
    • mm of induration: ____________
  o 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.

Physician or Health Care Provider Stamp Here

______________________________
Signature of Physician or Health Care Provider

______________________________
Address

______________________________
City, State, Zip

______________________________
Date

______________________________
Telephone