INTENSIVE ENGLISH PROGRAM

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)

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: _____
(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 (for students under 18 years old) Date

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(Last/Family) (First/Given)

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? ❑ **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 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