

MAIL HEALTH FORM TO:
University Health Center
Louisiana Tech University
P.O. Box 3023
Ruston, LA 71272-0001

**LOUISIANA TECH
UNIVERSITY**
RUSTON, LA 71272

For Office Use:
Coded _____
Initials _____

This information is strictly for the use of the University Health Center and will not be released to anyone without your knowledge and consent.

Please type or print. USE INK

MEDICAL HISTORY

Quarter for which you are applying – Fall/Winter/Spring/Summer: _____

Name (Mr.) (Mrs.) (Ms.) _____ Soc. Security # _____
Last First Middle Maiden

Date of birth ____/____/____ Age ____ COUNTRY of birth ____ Sex ____ Height ____ Weight ____

Present Mailing Address _____
Number Street City

State Zip Code Telephone Number Major

Next of Kin or person to notify in case of emergency: _____ Relationship _____

Address Tel. No. (work) (home)

IMMUNIZATION POLICY

Louisiana state law (Act 1047) requires that all persons who are entering Louisiana colleges and universities for the first time and whose date of birth is after 1956, must submit proof of immunization against preventable and/or communicable diseases, including Measles, Mumps, Rubella, and Tetanus-Diphtheria (MMR, Td).
Louisiana state law (Act 251) requires first time freshman to submit proof of immunization against meningitis.
Louisiana Tech University requires all new students born after December 31, 1956 to provide proof of immunization against MMR, Td and Meningitis. Forms for documenting immunization or establishing an exemption to this requirement are available from the Office of Admissions, Louisiana Tech University, Ruston, LA 71272.
Failure to complete and return these forms will result in the inability to complete the registration process.

LOUISIANA TECH UNIVERSITY REQUIRES PROOF OF THE FOLLOWING:

From all students born after December 31, 1956:

*Proof of immunity to Measles, Mumps, and Rubella. Acceptable proof includes:

- a) Protective serum titer for Rubella if no documentation of immunization, and
- b) Record of immunization signed by a physician or documentation by physician of Measles and Mumps disease

*Proof of meningitis vaccine.

*A Tetanus/Diphtheria combination within the past 10 years.

*Rubella vaccine: Date _____ or Rubella titer and date _____

*Measles vaccine: (FIRST) Date _____ (SECOND) Date _____ or Measles disease: Date _____
(Two Measles vaccines must be administered after January 1, 1968, and must have been given on or after the first birthday)

*Mumps vaccine: Date _____ or Mumps disease: Date _____

*Tetanus/Diphtheria combination: Date _____

*Meningitis vaccine: Date _____

Information on immunizations must be authenticated by a physician, Public Health Clinic, or transcript from school record. A photocopy of an official immunization record will also be acceptable.

SIGNATURE AND STAMP of FACILITY(REQUIRED) _____

ADDRESS STREET/PO BOX CITY STATE ZIP CODE

CERTIFICATE OF MEDICAL EXEMPTION

Medical exemption: The above named student is hereby granted a medical exemption on the basis of certain specific health/physical conditions which are recognized contradictions to the administration of required vaccines.

1. Temporary Exemption Reason _____
2. Permanent Exemption Reason _____

If permanent exemption due to contraindicated vaccines, are all vaccines contraindicated: Yes _____

No _____ If no, designated specific vaccine: _____

Signature of Student or Parent _____ Date _____

REQUEST FOR EXEMPTION – PERSONAL DISSENT

I am requesting exemption from compliance with Louisiana state laws (Act 1047 and 251) for the following personal reasons:

I understand if I claim exemption for personal or medical reasons, that in the event of an outbreak of measles, mumps, rubella or meningitis, I may be excluded from attendance of all campus activities, including classes, until the appropriate disease incubation period has expired or until I submit proof of immunization. If I am not 18 years of age, my parent or legal guardian must sign below.

Student's signature: _____ Date: _____

Parent or Guardian (if required): _____ Date: _____

PERSONAL HISTORY

Please answer all questions. Comment on all positive answers in the space below or on an additional sheet.

Are you allergic to:	Yes	No	Have you ever had:	Yes	No	Have you ever had:	Yes	No	Have you ever had:	Yes	No
Penicillin			Appendectomy			Shortness of breath			Head injury with unconsciousness		
Sulfa drugs			Tonsillectomy			High blood pressure			Diabetes		
Other drugs or medicine			Hernia repair			Palpitations (heart)			Seizures-epilepsy		
Food			Bone or joint surgery			Heart Murmur or Rheumatic fever			Depression or other emotional problems		
Anesthesia			Tumor, Cancer, Cyst			Lung disease			Recurrent headaches		
Other			Sinusitis			Chronic cough			Bleeding disorder		
Have you ever had:			Eye Disease			Peptic ulcer disease			Do you use tobacco?		
Hepatitis			Ear, nose, or throat disease			Gall Bladder disease			Alcohol? Other drug?		
Measles			Hay fever-asthma			Chronic diarrhea or colitis			Females Only		
Mumps			Uticaria (hives)			Kidney disease or blood or sugar in urine			Irregular periods		
Chicken Pox			Chest pain/pressure			Disease or injury of joints or bones			Severe cramps		
German measles (rubella)			Anemia			Sleep Problems			Excessive flow		
Malaria			Tuberculosis			Infectious Mononucleosis			Birth Control		

ADDITIONAL INFORMATION

	Yes	No	Comment on any items checked "Yes" in this Section
A. Are you presently taking any medicine on a regular basis? If so, list.			
B. Have you had any illness or injury or ever been hospitalized other than already noted? If so, list.			
C. Has your physical activity been restricted during the past five years? (Give reason)			
D. Have you been treated by clinics, physicians, or other therapists in the last five years other than already noted? If so, list.			
E. Have you ever been rejected for or discharged from military service or a civilian job because of physical or emotional reasons?			

Immunization Completed	Yes	No	Date of last Injection	Has anyone in your family ever had any of the following:	Yes	No	Relationship
Tetanus				Tuberculosis			
Diphtheria				Cancer, anemia, blood disease			
Measles (1 st)				Diabetes			
Measles (2 nd)				Kidney Disease			
Mumps				Heart Dis., high blood pressure			
Rubella				Arthritis			
Polio				Stomach Disease			
Pneumonia				Asthma or Hay Fever			
Typhoid				Epilepsy, Convulsions			
Hepatitis				Mental Illness			
Other							

To avoid any delay in registration, please complete and return this form at least four weeks prior to registration. You will not be able to register until this form, including documentation of required immunizations, is complete and on file with the University Health Center.