# PROOF OF IMMUNIZATION COMPLIANCE

**(Louisiana R.S. 17:170/R.S. 17:170.1 Schools of Higher Learning)**

# GRAMBLING STATE UNIVERSITY

G#: _____ Date of Birth: Month _____ Date _____ Year _____

Name: _____
Please Print (Last) (First) (Middle)

Address: _____

City: _____ State: _____ Zip Code: _____

## UNIVERSITY REQUIRED IMMUNIZATIONS:

**Physician or Other Health Care Provider Verification: (See other side)**

| **M-M-R (Measles, Mumps, Rubella-2 Doses required)** | | **Tetanus-Diphtheria (Td)** |
|---|---|---|
| First dose: _____ (Date)<br>Second dose: _____ (Date) | **OR**<br>Serologic Test: _____ (Date)<br>Result: _____<br>**OR** _____ Born before 1957 | Last dose: _____<br>(Date within 10 years) |

**Meningococcal Vaccine** (One dose—preferably at entry into college)

Quadrivalent vaccine (A, C, Y, W-135) ……Date: _____ Vaccine Type: _____

| | |
|---|---|
| _____ _____<br>**(Signature of Physician or Other Health Care Provider)** **Date** | **Please print office address or stamp here** |

## UNIVERSITY RECOMMENDED IMMUNIZATIONS:

**Physician or Other Health Care Provider Verification:**

| **Hepatitis B Vaccine** | **Varicella (chicken pox)** | |
|---|---|---|
| First dose: _____ (Date) | First dose: _____ (Date) | **OR**<br>Disease: _____ (Date) |
| Second dose: _____ (Date) | Second dose: _____ (Date) | **OR**<br>Serologic Test: _____ (Date) Result: _____ |
| Third dose: _____ (Date) | Varicella (either a history of chicken pox, a positive Varicella antibody, or two doses of a vaccine given at least one month apart if immunized after 13 years, meet the requirement) | |

**READ INFORMATION ON BACK OF THIS FORM**

You will *not* be permitted to register until you complete this form and return to:

Foster-Johnson Health Center
403 Main Street, Box 4251
(318) 274-2351 (Phone) Grambling, LA 71245 (318) 274-2481 (Fax)

**Please read the following information carefully:**

**Louisiana Law (R.S. 17:170/R.S. 17:170.1/Schools of Higher Learning)** requires all students entering Grambling State University to be immunized for the following: Measles (2 Doses), Mumps, Rubella—required for those born on or after January 1, 1957; Tetanus-Diphtheria (within the past 10 years); and against Meningococcal disease (Meningitis). The following guidelines presented on the back of this form are for the purpose of implementing the requirements of Louisiana R.S. 17:170.1, and of meeting the established recommendations for control of vaccine-preventable diseases as recommended by the American Academy of Pediatrics (AAP); the Advisory Committee on Immunization Practices to the United States Public Health Service (ACIP); and the American College Health Association (ACHA). Students not meeting the MMR & TD requirement will be prevented from registering for subsequent semesters. Student registration will not be complete until they have complied with the meningococcal vaccination requirement.

Name: _____ Date of Birth: _____ G#: _____

**REQUIREMENT**:
**TWO** (2) doses of measles vaccine; at least **one** (1) dose each of rubella and mumps vaccine; and a tetanus-diphtheria booster (AT LEAST 10 YEARS CURRENT).

**Measles requirement**: Two (2) doses of live vaccine given at any age, except that the vaccine must have been given on or after the first birthday, in 1968 or later, and without Immune Globulin. A second dose of measles vaccine must meet this same requirement, but should not have been given within 30 days of the first dose. A history of physician-diagnosed measles is acceptable for establishing immunity, but should be accepted with caution unless you were the diagnosing physician.

**Tetanus-Diphtheria requirement**: A booster dose of vaccine given within the past ten (10) years. Students can be considered to have completed a primary series earlier in life, unless they state otherwise.

**Meningitis Requirement:** One (1) dose of Menomune® (MPSV4) or Menactra™ (MCV4) preferably at entrance into college.

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**Request for Exemption--MMR & Td**

___Medical Reasons (Physician's Statement Required) ___Personal Reasons (State reason in space provided)
(REASON)_____

I fully understand that if I claim exemption for medical or personal reasons, 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. If I am not 18 years of age, my parent or legal guardian must sign below.

_____ _____ _____ _____
Student Signature Date Parent or Guardian Signature Date

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**Request for Exemption--Meningococcal Vaccine (Meningitis)**

Meningococcal disease is a serious disease that affects the brain and spinal cord. The disease is spread through droplet transmission from the nose or throat, such as sneezing or coughing, and direct contact with oral secretions of an infected individual. This includes such things as kissing, sharing drinks, food, utensils, cigarettes, lip balm or any object that has been in someone else's mouth. Because meningitis is a grave illness and can rapidly progress to death, it requires early diagnosis and treatment. This is often difficult because the symptoms closely resemble those of the flu and the highest incidence of meningitis occurs during late winter and early spring (flu-season). When not fatal, meningitis can lead to permanent disabilities such as hearing loss, brain damage or loss of limbs.

The U.S. Centers for Disease Control and Prevention (CDC) and the American College Health Association (ACHA) recommend that college students, particularly freshmen living in dormitories, are at a greater risk for meningitis than the general population. Behavior and social aspects of college lifestyle activities such as living in dormitories, bar patronage, smoking, and irregular sleep habits put these students at greater risk.

Two meningococcal vaccines are available in the US—Menomune® (MPSV4) and Menactra™ (MCV4). The vaccinations are effective against 4 of the 5 most common bacterial types that cause 70% of the disease in the U.S. **(but does not protect against all types of meningitis-DOES NOT COVER Group B serotype).** Vaccinations take 7-10 days to become effective, with possible protection lasting 3-5 years. As with any vaccine, vaccination may not protect 100% of all susceptible individuals.

Who should not get the vaccine: People who have had Guillain-Barré Syndrome; Over 55 years old; Pregnant or suspect that you may be; Allergic to thimerosal, a substance found in several vaccines; Have an acute illness, with fever (101°F or higher).

Reactions to the vaccine may include pain, redness, and induration at the site of injection, headache, fatigue, and malaise. The vaccine is contraindicated in persons with known hypersensitivity to any component of the vaccine or to latex, which is used in the vial stopper. Because of the risk of injection site hemorrhage, the vaccine should not be given to persons with any bleeding disorder or to persons on anticoagulant therapy unless the potential benefit clearly outweighs the risk of administration. A few cases of Guillain-Barré Syndrome, a serious nervous system disorder, have been reported among people who received the vaccine. As with any vaccine, there is a possibility of an allergic reaction.

Vaccination is available at University Health Center (limited supply), private physician offices, and Health Units. Cost of vaccine varies.

___Medical Reasons (Physician's Statement Required) ____ Personal Reasons (State reason in space provided)
____Unavailability of Vaccine (You will be expected to continue to search for means to acquire this vaccination such as your private physician's office & health departments.)
(REASON)_____

I have read the above information and am aware of my personal risk for meningitis and have ***chosen to sign this exemption from the meningococcal immunization requirement***. I fully understand that if I claim exemption for medical or personal reasons, I may be excluded from campus and from classes in the event of an outbreak of meningitis until the outbreak is over or until I submit proof of immunization. I understand that this puts me at greater risk of acquiring meningitis and Grambling State University, its Board of Trustees, the Department of Health and Hospitals, all their agents, attending health care professionals, and other personnel are released from any liability should I contract meningitis while I am enrolled. I declare myself to be mentally competent and hereby assume full responsibility for any and all possible present or future results or complications of my conditions as a result of not receiving the vaccination. If I am not 18 years of age, my parent or legal guardian must sign below.

_____ _____ _____ _____
Student Signature Date Parent or Guardian Signature Date

**Grambling State University**
**Foster-Johnson Health Center**
**403 Main Street, Box 4251**
**Grambling, LA 71245**
**(318) 274-2351 (phone)/(318) 274-2481 (fax)**
**www.gram.edu**

# MEDICAL HISTORY

Students are to complete the following form very carefully. All information is confidential, and is reviewed by Health Center Personnel only.

## Student Information (Please Print)

Name: _____
(Last) (First) (Middle)

Address: _____
(Street) (City) (State) (Zip Code)

Social Security Number: _____ Date of Birth: _____ Age: _____ Sex: _____

Telephone: (____) _____/Cell: (____) _____ Are you planning on living: __On Campus __ Off Campus

## Emergency Contact Information

Name: _____ Relationship: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Number: (____) _____

## Family History

Has any member of your family ever had any of the following? (Please Check)

| | | | |
|---|---|---|---|
| ___ Asthma or Hay Fever | ___ Cancer | ___ Convulsions/Seizures | ___ Diabetes |
| ___ Heart Disease | ___ High Blood Pressure | ___ Kidney Disease | ___ Mental Illness |
| ___ Rheumatism (arthritis) | ___ Sickle Cell | ___ Stomach, Intestinal Trouble | ___ Tuberculosis |

## Personal History

What is your Blood Type? _____
List any surgery, serious illnesses, or allergies (food or drug): _____
List any medical conditions you are currently being treated for: _____
List any medications you take on a regular basis: _____
Do you use any of the following? (Please Check)

| | | | |
|---|---|---|---|
| ___ Artificial Limb or Eye | ___ Braces | ___ Crutches | ___ Eye Glasses/Contact Lens |
| ___ Extremity or back | ___ Hearing Aid | ___ Wheelchair | |

Comments: _____

## Insurance

| Type | Company | Policy | Expiration Date |
|---|---|---|---|
| **Accident and Hospitalization** | | | |
| **Automobile** | | | |

## Medical Consent

In the event of a medical emergency or life-threatening situation and in consultation with university health service physician, nurse practitioners and nurses, I hereby grant permission to authorize medical treatment or other medical care that might be deemed necessary to my health and well-being; also when necessary for executing such care, permission for hospitalization at an accredited hospital is granted. I understand that I am responsible for personal expenses not provided by the student insurance plan. This medical consent is valid as long as the above student is enrolled at Grambling State University unless cancelled in writing.

_____ _____ _____ _____
(Signature of Student) Date (Signature of Parent/Legal Guardian, if required) Date

Name: _____ Date of Birth: _____ G#: _____

# TUBERCULOSIS QUESTIONNAIRE
## (MANDATORY – NO EXEMPTIONS)

**********

**Have you ever had a positive PPD skin test in the past?** **YES** **NO**

If yes, **STOP**. *Please submit evidence of treatment or if you have no evidence of treatment, please obtain QuantiFERON-TB Gold (QFT) or T-Spot blood test. If QFT or T-Spot is positive,* a letter from public health must be received in order to gain clearance for entrance to campus. ____ ____

**********

**PAST HISTORY**

| | YES | NO |
|---|---|---|
| 1. Were you born in, have you ever lived in, or recently traveled to (within the past 5 years) any country in the following areas of the world? *Africa, Asia, Caribbean nations, Central America (including Mexico), Eastern Europe, India and other Indian Subcontinent Nations, Middle East, Portugal, South America, South Pacific (except Australia and New Zealand), or Spain* | ____ | ____ |
| 2. Do you have a history of cancer, leukemia, kidney disease, diabetes, alcoholism, or intravenous drug use? | ____ | ____ |
| 3. Have you resided, worked or volunteered in a prison, homeless shelter, hospital, nursing home, or other long-term treatment facility? | ____ | ____ |
| 4. Do you have AIDS/HIV or take immunosuppressive medication such as prednisone? | ____ | ____ |
| 5. Have you been in close contact with someone with TB? | ____ | ____ |

**IMPORTANT: If the answer to all of the above questions is "NO", no TB testing or further action is required.**

**If you have answered "YES" to any of the above 5 questions listed under PAST HISTORY, you are required to have a PPD skin test within the past year. You can obtain the PPD skin test from your physician or student health center.**

**NOTE TO HEALTH CARE PROVIDERS:** Please record the size of the induration in millimeters. If there is no reaction, please record as "0 mm". **Students who have had a BCG vaccine are still required to have a PPD skin test**. If the screening skin test is positive (10mm or greater for those who answer "YES" to questions 1, 2, or 3, and 5mm or greater for those who answer "YES" to questions 4 or 5), we require the QuantiFERON-TB Gold (QFT) or T-Spot blood test to confirm the student has actually been exposed to TB in the past. (A chest x-ray is required if either test is positive.) **PLEASE FOLLOW THE CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) GUIDELINES FOR THE TREATMENT OF LATENT TUBERCULOSIS INFECTION (LTBI) – SEE WWW.CDC.GOV.**

Date PPD Applied: _____ Date PPD Read: _____ Size of Induration: _____ mm

Date of QFT or T-Spot (circle type): _____ Result: Negative_____ Positive_____ **(provide copy of result)**
**If QFT or T-Spot is positive, refer to public health. A letter from public health must be received in order to gain clearance for entrance to campus.**

Date of Chest X-ray: _____ Result: Normal_____ Abnormal_____

Name of Medication: _____ Date Initiated: _____

Health Care Provider's Name, Address, tele #: _____

Health Care Provider's Signature: _____

****REMEMBER! You will not be eligible to pay University fees until all immunization records are in compliance or the exemption is signed.**

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