# PROOF OF IMMUNIZATION COMPLIANCE

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

# GRAMBLING STATE UNIVERSITY

SS Number: _____ 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) | **OR** Serologic Test: _____ (Date) | Last dose: _____ (Date within 10 years) |
| Second dose: _____ (Date) | Result: _____ | |
| | **OR** _____ Born before 1957 | |

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

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

| | |
|---|---|
| _____ _____ **(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** | **Tuberculosis Test** |
|---|---|
| First dose: _____ (Date) | PPD (Mantoux) within the past 12 months (tine or monovac not acceptable) |
| Second dose: _____ (Date) | Date given: _____ Date read: _____ |
| Third dose: _____ (Date) | Result: Neg _____ Pos _____ mm induration (horizontal diameter) _____ |
| | *If PPD is positive, chest X-ray result: Normal _____ Abnormal _____ |
| | Date: _____ |

**Varicella (Chicken Pox)**

| | | |
|---|---|---|
| First dose: _____ (Date) Second dose: _____ (Date) | **OR** Disease: _____ (Date) | **OR** Serologic Test: _____ (Date) Result: _____ |

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 age 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.

**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)

_____

_____

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 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 |
|---|---|---|---|

Revised: 10/06

**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: (____) _____ 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 a physician, I hereby grant the University official permission to authorize medical treatment for _____. This medical consent is valid as long as the above student is enrolled at Grambling State University unless revoked in writing.

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

## PHYSICAL EXAMINATION

(to be completed by physician)

Height_____ Weight _____ Pulse _____ Respiration _____ Temperature _____ Blood Pressure _____

### CHECK EACH ITEM IN APPROPRIATE COLUMN:

| Items | Normal | Abnormal | Additional Comments |
|---|---|---|---|
| Head, face, scalp, skin | _____ | _____ | _____ |
| Neck, nodes, thyroid | _____ | _____ | _____ |
| Eyes, ears, nose, & sinuses | _____ | _____ | _____ |
| Mouth & teeth | _____ | _____ | _____ |
| Pharynx & tonsils | _____ | _____ | _____ |
| Lungs & chest | _____ | _____ | _____ |
| Breasts | _____ | _____ | _____ |
| Abdomen, hernia, scars | _____ | _____ | _____ |
| Genitalia & rectum (if indicated in females) | _____ | _____ | _____ |
| Extremities & feet | _____ | _____ | _____ |
| Spine & musculoskeletal | _____ | _____ | _____ |
| Reflexes | _____ | _____ | _____ |

Has this student any Chronic disease? _____ Explain _____

_____

Is this student on any medication (insulin, dilantin, allergy injections, etc.)? _____
If you will be receiving allergy injections, bring medication with physician's orders.

Give information as to medication name, dosage, etc. _____

_____

Is this student allergic to drugs, medicines, serum, etc? _____ Explain _____

_____

### CHECK ALL PHYSICAL ACTIVITIES IN WHICH STUDENT MAY PARTICIPATE:

1. ___ All contact sports and physical exercise
2. ___ All non-contact sports and physical exercise
3. ___ Limited physical exercises
4. ___ No Physical exercises
5. ___ Gymnastics

If number 3 or 4 is recommended, please give explanation _____

_____

_____ _____ _____

Signature of Physician | Date of Examination | Please print office address or stamp here

**IMMUNIZATION:** **Copy of immunization record including Measles (2 doses), Mumps, Rubella (for those born after 1956); Tetanus-Diphtheria (within the past 10 years); and Meningococcal (Meningitis) vaccine or a signed exemption must accompany Medical History. This is a prerequisite for registration.**

Failure to execute this form will relieve the University of any liability.

*Return this form to the address provided on front*

Revised: 10/06