Please return the completed form to: University of Louisiana at Lafayette; Student Health Service: PO Box 43692, Lafayette, LA 70504-3692, Fax: 337-482-1873

lame:		Date	of Birth:	CLID/SSN:
Name:(Last/Family)	(First/Given)			
When do you plan to start at UL Lafayette:	N	Month	Year	
:mail:	Telephone: _			
Instructions: Immunization requirements are application with the second point of the s	provider complete Sec lic Health. by completing Section E	ction A or subm B. However, Sec	nit the Universal ction C cannot be	. If you have not been immunized for all waived and must be completed.
: Failure to complete turn	n in this form will	you from b	eing able to sche	dule classes.
			Da	te of 1st dose:
			Da	te of 2nd dose:
Date:			Da	te:
Vaccine type:				
			Da	te:
Date:				
Vaccine type:				
(Minimum interval is eight weeks) Date:				
Vaccine type:				
		1		sen not to b vaccinated 6 r and am re e sting
		, and	ı am aware or	the risks.
Medical Personal Sh	ortage (unable to locate	e vaccine)	Other: _	
understand that if I claim an exemption for per- utbreak of measles, mumps, rubella, or meningit garding vaccine-preventable diseases and related tp://www.cdc.gov/vaccines/hcp/vis/index.html. If I ar	sonal or medical reasonal or medical reasonal in the outbreak in the decimations contained to the contained	ons, I may be is over or until ed on the webs	excluded from a large submit proof site for the Cent	campus and from classes in the event of an of immunization. I have reviewed information er for Disease Control and Prevention (CDC):

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Name:				Date of Birth:_		_ CLID/SSN:	
	(Last/Family)		(First/Given)				
Countr	y of Origin:						
Instruc	If the answer is to If the answer is to You are required to have	o any of the below question we a tuberculin skin test (P from your physician or wal	testing or action is rens, you are required to PD). You may use reck-in clinic.	have your physician or	kin test if it wa	as within the last 12 month	
	I allule	o complete turn in the	iis ioiiii wiii	you from being able to	Scriedule clas		
2. Were	you born in, have you ex Africa, Asia, Central Ar and other Indian Subc South Pacific (except A	act with persons known or ver lived in, or recently trav merica (including Mexico), ontinent Nations, Middle E Australia and New Zealand berculosis vaccination)? If	veled (within the past Eastern Europe, India ast, Portugal, South A	5 years for 2 hours or m a America,	ore) to a high	risk country?	
	ctions: Section C, Part II	to be completed only if the	nere is a answer	to any questions from S	Section C, Par	t I. Section C, Part II to b	e completed
•	Persons answering YE Release Assay (IGRA) Refer to www.cdc.gov	ify the 3 questions from S to any of the questions, unless a previous positive for interpretation of TST relitive: IGRA is required estitive: refer to public health should be based on actual ate applied:	in a re test has been docu esults: th al millimeters (mm) of	mented. induration; if none, write		ulin skin test (TST) or Inte	rferon Gamma
	• m	m of induration:	Interpretation:	(circle one)	or		
		ate obtained:		(circle or fll in blank)	or	or	
٠	Assessment: (please of TST is negative: TST is positive of TST is posi		ed. urther action is require to public health (pleas	ed. se specify)			
				Physician	or Health C	are Provider Stamp He	ere
Signatu	ıre of Physician or Healt	n Care Provider					
Address	S						
City, Sta	ate, Zip						
Date		Telephone					