



Proof of Immunization Compliance

Louisiana R.S. 17:170/Schools of Higher Learning

Last Name:	First Name: MI:	Date of Birth:
Applicant Email:	Applicant Phone Number:	
	Return Instructions	
For A	pplicants: Scan and email or mail to address below	v
Email: edd@nobts.edu	Mail: P.O. Box 131 3939 Gentilly F	Blvd, New Orleans, La 70126
	ysician or Other Health Care Provider Verif Tetanus-Diphtheria	ication
Measles (Rubeola) The state of Louisiana requires proof of two measles vaccinations for students enrolling at Louisiana	Required within the past ten years. Date of Immunization:/ Please check: TD TDAP	Mumps Date of Immunization:/
institutions of higher learning born after 1/1/57. Date of 1st Immunization:/	Mumps and Rubella	Date of Serologic Proof of Immunity:// Must attach lab results of serologic proof
Date of 2nd Immunization:/	The state of Louisiana requires proof of one vaccination against mumps and rubella for all new students enrolling at Louisiana institutions of higher learning	Rubella (German measles) Date of Immunization://
Date of Serologic Proof of Immunity:// Must attach lab results of serologic proof	born after 1/1/57.	Date of Serologic Proof of Immunity:/ Must attach lab results of serologic proof
		Place Clinic Stamp Below
Address:		
	Request for Exemption from Immunization	
f you request an immunization exemption for po Medical (physician statement required Personal (student or parent state reas Shortage (unable to locate vaccine)	•	opriate blank and provide the information requeste
Statement from Physician, Student, or Parent (i	f applicant under 18):	
		Physician/Student/Parent
Signature:	Date:	
	excluded from campus and from classes in the ev of immunization. I do further free and release NOE	
Student's Signature	Dat	e:

Parent/Legal Guardian Signature (if applicant under 18) _______ Date: ______





Tuberculosis Targeted Testing

Louisiana R.S. 17:170/Schools of Higher Learning

Last Nam	First Name: MI: Date of Birth: Sec	ctior	1	
	One: Section One: Questionnaire			
Please	answer the following questions:	es	1	
1. Have	ou traveled in the past 5 years or lived more than 6 weeks in Africa, East Europe, Asia, Middle East, or South/Central America?			
2. Do yo use? (Fa	have a personal history of cancer, leukemia, kidney disease, diabetes, alcoholism, or intravenous drug nily history does not apply)			
3. Have you been a resident, employee, or volunteer in a prison, nursing home, homeless shelter, hospital, or long-term treatment facility?				
4. Have	u ever been vaccinated with BCG Tuberculosis vaccination?			
5. Do yo	have AIDS/HIV or take medications that suppress the immune system such as prednisone?			
6. Have	ou ever had close contact with persons known or suspected to have active TB disease?			
7. Have	u ever tested positive for TB?			
If the answ	r to all of the above questions is NO, sign below and return this document to the Doctor of Education office.			
Signature:	DateIf the answer is YES			
to any of t	e above questions, NOBTS requires results of TB testing within the past year.			
A healthca	e provider should complete section two of this form below.			
	Section Two: Test Results			
	erculin Skin Test-Positive if \geq 10mm for questions 1, 2, 3, or 4 or \geq 5mm for questions 5 or 6.			
	ate Given: Date Read: Result:mm of induration Interpretation: Positive Negative			
	T or T-SPOT is required if PPD is positive. A Chest X-Ray will not be accepted in its place. (Please provide a copy of results.) ed: Circle Method Given: QFT T-SPOT Result: Positive Negative:			
Step 3: Stu	ents with a positive QFT or T-SPOT should receive a Chest X-Ray.			
	ate of X-Ray: Result: Normal Abnormal:			
	ents with a positive QFT or T-SPOT with no signs of active disease on chest X-Ray are recommended to be treated for Latent TB wopropriate medication. The state of medication for treatment:	<i>r</i> ith		
	ate initiated and duration of treatment:			
	ease provide a copy of completion of treatment.			
-	Student has been treated or agrees to receive treatment.			
	Student declines treatment at this time and agrees to routine checkups to monitor progression of Latent TB.			

Name of Health Care Provider (Print):		Address:
Signature of Health Care Provider:	_ Date:	