

**DIRECTIONS FOR COMPLETION OF THE 3 PAGE  
IMMUNIZATION COMPLIANCE FORM**

PAGE 1

**PLEASE NOTE:**

Pages 2 and 3 must be completed, signed and stamped by the students physician or medical provider, **NO ATTACHMENTS ACCEPTED!**

Page 4 is required if any questions on page 3 are answered "yes."

**TO THE PHYSICIAN OR OTHER MEDICAL PROVIDER**

The following guidance is presented for the purpose of implementing the requirements of Louisiana R.S. 17:170, Act 251 & 711 and, in meeting the established recommendations for control of vaccine-preventable diseases as recommended by the American Academy of Pediatrics; the Advisory Committee on Immunization Practices to the United States Public Health Service; and the American College Health Association.

**Measles, Mumps, Rubella requirement:** *Two (2) doses of live vaccine required. The vaccine must have been given, on, or after the first birthday. A second dose measles vaccine must meet the same requirement, but should not have been given within 30 days of the first dose.*

**Tetanus-Diphtheria-Pertusis requirement:** A booster dose of vaccine given within the past ten (10) years required. Since 2006, 1 booster dose including pertusis (Tdap) is recommended. U. S. born students can be considered to have completed a primary series earlier in life, unless they state otherwise.

**Meningococcal/Meningitis Vaccine:** Required by Louisiana law for ALL college freshmen. Required by Tulane for any student in on-campus housing and fraternity/sorority housing.

**PLEASE NOTE:**

If Tulane University has not received documentation of the meningococcal (Menactra) vaccine by "move in day," **you will not be permitted to move into your dormitory/residence hall.** The vaccine is available at Student Health during all summer orientation sessions and on move-in day.

To sign a personal exemption for meningococcal vaccine, student (parent/guardian if student is under 18 years of age) must appear in person at the Student Health Center to receive information about the disease from a college health professional.

**Tuberculosis (TB) Screening/Testing:** See page 3 and 4. It is recommended that students who were born in or traveled to or in a country with high tuberculosis incidence rates be screened with the tool listed on page 3. If appropriate, the TB risk assessment on page 4 should be completed.

**Hepatitis B Vaccine:** (Recommended for college entrance) series of (3) doses, given at 0, 1 month and 6 months, prior to college entry. Vaccination should be noted on the Tulane Proof of Immunization Form.

Return or fax completed form to: Tulane University  
Student Health Center  
Building 92  
New Orleans, LA 70118-5698

FAX: 504.865.5083

PHONE: 504.865.5255 press 1

**STUDENT COMPLETES**

Name: \_\_\_\_\_  
Please Print (Last) (First) (MI)

SS Number/Student ID: |\_\_|\_|\_|\_| - |\_\_|\_|\_|\_| - |\_\_|\_|\_|\_| | Date of Birth: Month \_\_\_ Date \_\_\_ Year \_\_\_

email: \_\_\_\_\_ Country of birth: \_\_\_\_\_  
 Country of residence: \_\_\_\_\_

Circle the school you are entering: Newcomb/Tulane College    Law    Medicine    Public Health    Social Work    Other Graduate    Continuing Studies

Circle your status:    Full time    Part time

**List all allergies to medications; listing an allergy MUST INCLUDE type of reaction.**

Allergic to: \_\_\_\_\_ Reaction type \_\_\_\_\_  
 \_\_\_\_\_

**PROVIDER RECOMMENDED COMPLETES REQUIRED**

**\*HEALTH CARE PROVIDER VERIFICATION\***

**I. PLEASE GIVE YOUR PATIENT ANY MISSING IMMUNIZATIONS FOLLOWING REQUIREMENTS LISTED ON DIRECTIONS PAGE 1.**

Measles, Mumps, Rubella MMR	Tetanus-Diphtheria-Pertussis	Meningococcal																														
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th>M</th> <th>Day</th> <th>Yr</th> </tr> <tr> <td>#1: _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>and</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>#2: _____</td> <td>_____</td> <td>_____</td> </tr> </table>	M	Day	Yr	#1: _____	_____	_____	and	_____	_____	#2: _____	_____	_____	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th>M</th> <th>Day</th> <th>Yr</th> </tr> <tr> <td><b>Tdap preferred</b> May be given as soon as 2 yrs after last Td booster or</td> <td>_____</td> <td>_____</td> </tr> <tr> <td><b>Td</b> Booster within 10 years</td> <td>_____</td> <td>_____</td> </tr> </table>	M	Day	Yr	<b>Tdap preferred</b> May be given as soon as 2 yrs after last Td booster or	_____	_____	<b>Td</b> Booster within 10 years	_____	_____	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th>M</th> <th>Day</th> <th>Yr</th> </tr> <tr> <td><b>Menactra</b> Required for all freshman/transfer students and any on-campus residents.</td> <td>_____</td> <td>_____</td> </tr> <tr> <td colspan="3">Living on campus?    Yes <input type="checkbox"/>    No <input type="checkbox"/></td> </tr> </table>	M	Day	Yr	<b>Menactra</b> Required for all freshman/transfer students and any on-campus residents.	_____	_____	Living on campus?    Yes <input type="checkbox"/> No <input type="checkbox"/>		
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and	_____	_____																														
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Living on campus?    Yes <input type="checkbox"/> No <input type="checkbox"/>																																

**II. HEPATITIS B VACCINE SERIES:** Recommended for all adolescents prior to college entry, it is a series of three doses (0, 1, and 6 months.)

#1.    M / D / Y    #2.    M / D / Y    #3.    M / D / Y

**III. QUADRIVALENT HUMAN PAPILLOMAVIRUS VACCINE (HPV)**  
 (Three doses of vaccine for female college students 11-26 years of age at 0, 2, and 6 months.)

#1.    M / D / Y    #2.    M / D / Y    #3.    M / D / Y

**IV. HEPATITIS A:** Series of two doses (0 and 6-12 months)

#1    M / D / Y    #2    M / D / Y

**V. OTHER: VARICELLA; etc.** \_\_\_\_\_

**HEALTH CARE PROVIDER**

Name \_\_\_\_\_  
 Signature \_\_\_\_\_

Clinic stamp here:

*REQUEST FOR EXEMPTION FROM IMMUNIZATION:*

If you request exemption for medical or personal reasons, please check the appropriate box and provide the information requested.

Medical reasons                       Personal reasons                       Religious reasons

State Reasons: \_\_\_\_\_

I understand that if I claim exemption I may be excluded from campus and from classes in the event of an outbreak of meningitis, measles, mumps, or rubella until the outbreak is over or I submit proof of immunization. If I am not 18 years of age, my legal guardian must sign below.

\_\_\_\_\_

(Student's Signature)                                      (Date)                                      (Parent or Guardian, if required)                                      (Date)

**IMPORTANT: Make a copy of this form for your personal record.**

# IMMUNIZATION RECORD (PAGE 3)

## TUBERCULOSIS (TB) SCREENING/TESTING I

Please answer the following questions:

Have you ever had a positive TB skin test? Yes  No

Have you ever had close contact with anyone who was sick with 'TB'? Yes  No

Were you born in one of the countries listed below and arrived in the U.S. within the past 5 years? Yes  No   
 (If yes, please circle  the country)

Have you ever traveled\*\* to or lived in for more than 4 weeks one or more of the countries listed below? Yes  No   
 (If yes, please check  the country/ies)

Have you ever been vaccinated with BCG? Yes  No

*\*future CDC updates may eliminate the 5 year time frame*

*\*\* The significance of the travel exposure should be discussed with a health care provider and evaluated*

Afghanistan	Congo DR	Kenya	New Caledonia	Sri Lanka
Algeria	Cote d'Ivoire	Kiribati	Nicaragua	Sudan
Angola	Croatia	Korea-DPR	Niger	Suriname
Anguilla	Djibouti	Korea-Republic	Nigeria	Syrian Arab Republic
Argentina	Dominican Republic	Kuwait	Niue	Swaziland
Armenia	Ecuador	Kyrgyzstan	N. Mariana Islands	Tajikistan
Azerbaijan	Egypt	Lao PDR	Pakistan	Tanzania-UR
Bahamas	El Salvador	Latvia	Palau	Thailand
Bahrain	Equatorial Guinea	Lesotho	Panama	Timor-Leste
Bangladesh	Eritrea	Liberia	Papua New Guinea	Togo
Belarus	Estonia	Lithuania	Paraguay	Tokelau
Belize	Ethiopia	Macedonia-TFYR	Peru	Tonga
Benin	Fiji	Madagascar	Philippines	Tunisia
Bhutan	French Polynesia	Malawi	Poland	Turkey
Bolivia	Gabon	Malaysia	Portugal	Turkmenistan
Bosnia & Herzegovina	Gambia	Maldives	Qatar	Tuvalu
Botswana	Georgia	Mali	Romania	Uganda
Brazil	Ghana	Marshall Islands	Russian Federation	Ukraine
Brunei Darussalam	Guam	Mauritania	Rwanda	Uruguay
Bulgaria	Guatemala	Mauritius	St. Vincent &	Uzbekistan
Burkina Faso	Guinea	Mexico	The Grenadines	Vanuatu
Burundi	Guinea-Bissau	Micronesia	Sao Tome & Principe	Venezuela
Cambodia	Guyana	Moldova-Rep.	Saudi Arabia	Viet Nam
Cameroon	Haiti	Mongolia	Senegal	Wallis & Futuna islands
Cape Verde	Honduras	Montenegro	Seychelles	W. Bank & Gaza Strip
Central African Rep.	India	Morocco	Sierra Leone	Yemen
Chad	Indonesia	Mozambique	Singapore	Zambia
China	Iran	Myanmar	Solomon Islands	Zimbabwe
Colombia	Iraq	Namibia	Somalia	
Comoros	Japan	Nauru	South Africa	
Congo	Kazakhstan	Nepal	Spain	

Source: World Health Organization Global Tuberculosis Control, WHO Report 2006, Countries with Tuberculosis incidence rates of > 20 cases per 100,000 population. For future updates, refer to [www.who.int/globalatlas/dataQuery/default.asp](http://www.who.int/globalatlas/dataQuery/default.asp)

**If the answer is YES to any of the above questions, Tulane University requires** that a health care provider complete the tuberculosis risk assessment on page 4 (to be completed within 6 months prior to the start of classes).

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

### HEALTH CARE PROVIDER

Name \_\_\_\_\_

Signature \_\_\_\_\_

Clinic stamp here:

# IMMUNIZATION RECORD (PAGE 4)

## TUBERCULOSIS (TB) RISK ASSESSMENT

Persons with any of the following risk factors are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented:

Recent close contact with someone with infectious TB disease Yes \_\_\_\_\_ No \_\_\_\_\_

Foreign-born from (or travel\* to/in) a high-prevalence area (e.g., Africa, Asia, Eastern Europe, or Central or South America)

Yes \_\_\_\_\_ No \_\_\_\_\_

Fibrotic changes on a prior chest x-ray suggesting inactive or past TB disease Yes \_\_\_\_\_ No \_\_\_\_\_

HIV/AIDS Yes \_\_\_\_\_ No \_\_\_\_\_

Organ transplant recipient Yes \_\_\_\_\_ No \_\_\_\_\_

Immunosuppressed (equivalent of > 15 mg/day of prednisone for >1 month or TNF-cc antagonist) Yes \_\_\_\_\_ No \_\_\_\_\_

History of illicit drug use Yes \_\_\_\_\_ No \_\_\_\_\_

Resident, employee, or volunteer in a high-risk congregate setting (e.g., correctional facilities, nursing homes, homeless shelters, hospitals, and other health care facilities) Yes \_\_\_\_\_ No \_\_\_\_\_

Medical condition associated with increased risk of progressing to TB disease if infected [e.g., diabetes mellitus, silicosis, head, neck, or lung cancer, hematologic or reticuloendothelial disease such as Hodgkin's disease or leukemia, end stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight (i.e., 10% or more below ideal for the given population)] Yes No

*\*The significance of the travel exposure should be discussed with a health care provider and evaluated.*

### 1. Does the student have signs or symptoms of active tuberculosis disease? Yes \_\_\_\_\_ No \_\_\_\_\_

If No, proceed to 2 or 3. If Yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

### 2. Tuberculin Skin Test (TST)

(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0".

The TST interpretation should be based on mm of induration as well as risk factors.)\*\*

Date Given: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
M D Y

Date Read: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
M D Y

Result: \_\_\_\_\_ mm of induration

\*\*Interpretation: positive \_\_\_\_\_ negative \_\_\_\_\_

Date Given: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
M D Y

Date Read: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
M D Y

Result: \_\_\_\_\_ mm of induration

\*\*Interpretation: positive \_\_\_\_\_ negative \_\_\_\_\_

### 3. Interferon Gamma Release Assay (IGRA)

Date Obtained: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (specify method) QFT-G QFT-GIT other \_\_\_\_\_  
M D Y

Result: negative \_\_\_\_\_ positive \_\_\_\_\_ intermediate \_\_\_\_\_

Date Obtained: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (specify method) QFT-G QFT-GIT other \_\_\_\_\_  
M D Y

Result: negative \_\_\_\_\_ positive \_\_\_\_\_ intermediate \_\_\_\_\_

### 4. Chest x-ray: (Required if TST or IGRA is positive)

Date of chest x-ray: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
M D Y

Result: normal \_\_\_\_\_ abnormal \_\_\_\_\_

#### \*\* Interpretation guidelines

##### >5 mm is positive:

- Recent close contacts of an individual with infectious TB
- Persons with fibrotic changes on a prior chest x-ray consistent with past TB disease
- Organ transplant recipients
- Immunosuppressed persons: taking > 15 mg/d of prednisone for > 1 month; taking a TNF-cx antagonist
- Persons with HIV/AIDS

##### > 10 mm is positive:

- Persons born in a high prevalence country or who resided in one for a significant\* amount of time
- History of illicit drug use
- Mycobacteriology laboratory personnel
- History of resident, worker or volunteer in high-risk congregate settings
- Persons with the following clinical conditions: silicosis, diabetes mellitus, chronic renal failure, leukemias and lymphomas, head, neck or lung cancer, low body weight (>10% below ideal), gastrectomy or intestinal bypass, chronic malabsorption syndromes

*\*The significance of the exposure should be discussed with a health care provider and evaluated.*

##### > 15 mm is positive:

- Persons with no known risk factors for TB disease

## HEALTH CARE PROVIDER

Name \_\_\_\_\_

Signature \_\_\_\_\_

Clinic stamp here: