LSU Health SHREVEPORT Student Immunization Form

Last Name: _____ **First Name**: _____ **Middle Initial:** _____
Date of birth: _____**Street Address:** _____
Cell Phone: _____ **City:** _____
Primary Email: _____ **State:** _____ **Zip Code:** _____

Required Immunizations/Vaccinations

MMR (Measles, Mumps, Rubella) – *2 doses of MMR vaccine or two (2) doses of Measles, two (2) doses of Mumps and (1) dose of Rubella; or serologic proof of immunity for Measles, Mumps and/or Rubella. Choose only one option.* *Note: a 3rd dose of MMR vaccine may be advised during regional outbreaks of measles or mumps if original MMR vaccination was received in childhood.*				Copy Attached
Option1	**Vaccine**	**Date**		
MMR *-2 doses of MMR vaccine*	MMR Dose #1			
	MMR Dose #2			
Option 2	**Vaccine or Test**	**Date**		
Measles *-2 doses of vaccine or positive serology*	Measles Vaccine Dose #1		**Serology Results**	
	Measles Vaccine Dose #2		Qualitative ☐ Positive ☐ Negative	
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results: _____ IU/ml	
Mumps *-2 doses of vaccine or positive serology*	Mumps Vaccine Dose #1		**Serology Results**	
	Mumps Vaccine Dose #2		Qualitative ☐ Positive ☐ Negative	
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results: _____ IU/ml	
Rubella *-1 dose of vaccine or positive serology*			**Serology Results**	
	Rubella Vaccine		Qualitative Titer Results: ☐ Positive ☐ Negative	
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results: _____ IU/ml	
Tetanus-diphtheria-pertussis – *1 dose of adult Tdap; if last Tdap is more than 10 years old, provide date of last Td or Tdap booster*				
	Tdap Vaccine (Adacel, Boostrix, etc)			
	Td Vaccine or Tdap Vaccine booster *(if more than 10 years since last Tdap)*			
Varicella (Chicken Pox) - *2 doses of varicella vaccine or positive serology*				
	Varicella Vaccine #1		**Serology Results**	
	Varicella Vaccine #2		Qualitative ☐ Positive ☐ Negative	
	Serologic Immunity (IgG antibody titer)		Quantitative Titer Results: _____ IU/ml	
Influenza Vaccine --*1 dose annually each fall*				
		Date		
	Flu Vaccine			

Hepatitis B Vaccination *--3 doses of Engerix-B, Recombivax or Twinrix or 2 doses of Heplisav-B followed by a **QUANTITATIVE** Hepatitis B Surface Antibody (titer) preferably drawn 4-8 weeks after the last dose. If negative titer (<10 IU/ml) complete a second Hepatitis B series followed by a repeat titer. If Hepatitis B Surface Antibody titer is negative after a secondary series, additional testing including Hepatitis B Surface Antigen should be performed. See: http://www.cdc.gov/mmwr/pdf/rr/rr6210.pdf for more information. Documentation of Chronic Active Hepatitis B is for rotation assignments and counseling purposes only.*				Copy Attached
Primary Hepatitis B Series Heplisav-B only requires two doses of vaccine followed by antibody testing	3-dose vaccines (Engerix-B, Recombivax, Twinrix) or 2-dose vaccine (Heplisav-B)	**3 Dose Series**	**2 Dose Series**	
	Hepatitis B Vaccine Dose #1			
	Hepatitis B Vaccine Dose #2			
	Hepatitis B Vaccine Dose #3			
	QUANTITATIVE Hep B Surface Antibody		_____ IU/ml	
Secondary Hepatitis B Series *Only If no response to primary series* Heplisav-B only requires two doses of vaccine followed by antibody testing		**3 Dose Series**	**2 Dose Series**	
	Hepatitis B Vaccine Dose #4			
	Hepatitis B Vaccine Dose #5			
	Hepatitis B Vaccine Dose #6			
	QUANTITATIVE Hep B Surface Antibody		_____IU/ml	
Hepatitis B Vaccine Non-responder (If Hepatitis B Surface Antibody Negative after Primary and Secondary Series)	Hepatitis B Surface Antigen		☐ Positive ☐ Negative	
	Hepatitis B Core Antibody		☐ Positive ☐ Negative	
Chronic Active Hepatitis B	Hepatitis B Surface Antigen		☐ Positive ☐ Negative	
	Hepatitis B Viral Load		_____copies/ml	

Additional Vaccines		
Vaccination	**Date**	
Meningococcal Vaccine ACWY		
Covid-19 Vaccination (Please provide documentation of the 2 shot vaccine series OR the Johnson and Johnson 1 shot)		

CDC Recommendations: Preplacement (baseline) TUBERCULOSIS SCREENING AND TESTING of all health care personnel/ trainees consists of a TB symptom evaluation, a TB test (IGRA or TST), and an individual TB risk assessment. You only need to complete ONE section below: A or B or C.

Section A: If you do not have a history of TB disease or LTBI (Latent Tuberculosis Infection), the results of a 2-step TST (Tuberculosis Skin Test), or TB IGRA (Interferon Gamma Release Assay) blood test are required, **regardless** of your prior BCG status. You should also check off the results of your individual baseline TB symptom evaluation and TB risk assessment questionnaire.

Section B: If you have a history of a positive TST (PPD)≥10mm or a positive IGRA, please supply information regarding further medical evaluation and treatment below.

Section C: History of active tuberculosis, diagnosis and treatment.

Health Care Personnel with a baseline NEGATIVE Skin Test result or a NEGATIVE IGRA blood test and negative symptom evaluation will receive annual TB education; additional TB screening may be recommended by state or local health departments for certain occupational high risk groups.

Tuberculosis Screening History

Please complete only one TB section based on your history

Section A		Date Placed	Date Read	Result	Interpretation	Copy Attached
No history of prior TB Disease or LTBI Dates of the last 2-step TST or TB IGRA blood test are required (IGRAs include QuantiFERON TB Gold Test, QuantiFERON TB Gold in-tube test, or T-spot TB Test)	**TST step #1**			____mm	☐ Pos ☐ Neg ☐ Equiv	
	TST step #2			____mm	☐ Pos ☐ Neg ☐ Equiv	
			Date	**Result**		
	QuantiFERON TB Gold or T-Spot (Interferon Gamma Release Assay)			☐ Negative ☐ Indeterminate		
	QuantiFERON TB Gold or T-Spot (Interferon Gamma Release Assay)			☐ Negative ☐ Indeterminate		
	Individual TB Symptom Assessment			☐ Negative ☐ Positive (Medical follow-up needed)		
	Individual TB Risk Assessment			☐ Negative ☐ Positive (Increased risk TB infection)		
Section B		**Date Placed**	**Date Read**	**Result**		
History of LTBI, Positive TB Skin Test, or Positive TB IGRA Blood Test (IGRAs include QuantiFERON TB Gold Test, QuantiFERON TB Gold in-tube test, or T-spot TB Test)	Positive TST			_____ mm		
			Date	**Result**		
	QuantiFERON TB Gold or T-Spot (Interferon Gamma Release Assay)			☐ Positive ☐ Negative ☐ Indeterminate		
	Chest X-ray					
	Treated for **latent** TB?			☐ Yes ☐ No		
	If treated for **latent** TB, list medications taken:					
	Total Duration of treatment **latent** TB?			_____Months		
	Date of Last Annual TB Symptom Questionnaire					
Section C				**Date**		
History of Active Tuberculosis	Date of Diagnosis					
	Date of Treatment Completed					
	Date of Last Annual TB Symptom Questionnaire					
	Date of Last Chest X-ray					

MUST BE COMPLETED BY YOUR HEALTH CARE PROVIDER

Authorized Signature:		**Date:**
Printed Name:		Office Use Only
Title:		
Address Line 1:		
Address Line 2:		
City:		
State:		
Zip:		
Phone:	**(____) _____-_____ Ext: _____**	
Fax:	**(____) _____-_____**	
Email Contact:		

Updated 9/27/2021