

# STUDENT HEALTH SERVICES

LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER  
2020 GRAVIER STREET  
NEW ORLEANS, LOUISIANA 70112

School \_\_\_\_\_  
Program \_\_\_\_\_  
Entrance Date \_\_\_\_\_  
Month \_\_\_\_\_ Year \_\_\_\_\_

FULL AND PRECISE INFORMATION IS A REQUIREMENT FOR REGISTRATION.  
EACH QUESTION MUST BE ANSWERED. INCOMPLETE RECORDS ARE NOT ACCEPTED.

PRINT OR TYPE ALL INFORMATION

**MEDICAL HISTORY: Students are to complete this section very carefully. In the event of a medical emergency such information will be valuable. Your report will be available only to Student Health Services and appropriate administrative officers of the school.**

Name (in full) \_\_\_\_\_  
Last First Middle or Maiden

Address \_\_\_\_\_ Telephone ( ) \_\_\_\_\_ - \_\_\_\_\_

Birthdate \_\_\_\_\_ Marital Status \_\_\_\_\_ Sex \_\_\_\_\_ Social Security No.; \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

## PERSON TO BE NOTIFIED IN THE EVENT OF SERIOUS ACCIDENT OR ILLNESS:

Name (in full) \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Telephone ( ) \_\_\_\_\_ - \_\_\_\_\_

Office Address \_\_\_\_\_ Telephone ( ) \_\_\_\_\_ - \_\_\_\_\_

## YOUR FAMILY PHYSICIAN

Name \_\_\_\_\_ Office Telephone ( ) \_\_\_\_\_ - \_\_\_\_\_

Office Address \_\_\_\_\_

History  Heart Disease  Hypertension  Diabetes  Kidney Disease  Emotional Problems  
 Communicable Diseases  Illnesses  Injuries  Operations  ADD/ADHD

Specify \_\_\_\_\_

Are you allergic to any medications, drugs, or foods? (Specify) \_\_\_\_\_

Medications taken regularly \_\_\_\_\_

Do you use (Yes or No) Alcohol \_\_\_\_\_ Tobacco \_\_\_\_\_ Drugs \_\_\_\_\_

Do you have any disabilities \_\_\_\_\_ Explain \_\_\_\_\_

Do you use any of the following?  Yes  No If yes, check appropriately and explain. Hearing Aid \_\_\_\_\_

Wheelchair \_\_\_\_\_ Eyeglasses, contact lens \_\_\_\_\_ Crutches \_\_\_\_\_

Artificial limb or eye \_\_\_\_\_ Braces: extremity or back \_\_\_\_\_

Do you have Health or Accident Insurance?  Yes  No If yes, identify the Insurance Company:

Name of Company \_\_\_\_\_ Company Address \_\_\_\_\_ Policy No. \_\_\_\_\_

Date \_\_\_\_\_ Student's Signature \_\_\_\_\_

## MEDICAL CONSENT---IMPORTANT

In case of a medical emergency, call:  University Physician  Local personal physician

Local Physician's Name \_\_\_\_\_

Address \_\_\_\_\_ Office Telephone ( ) \_\_\_\_\_ - \_\_\_\_\_

*If the attempt to reach my personal physician is unsuccessful, I authorize the University Physician to prescribe such treatment as he/she reasonably judges to be in my best interest, and authorize him/her and those he/she directs to administer that treatment.*

Date \_\_\_\_\_ Student's Signature \_\_\_\_\_

**MEDICAL EXAMINATION**

(To be completed by physician not more than 90 days before registration)

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood pressure (sitting) \_\_\_\_\_ Pulse (sitting) \_\_\_\_\_ Resp \_\_\_\_\_

CHECK EACH ON THE APPROPRIATE COLUMN:

	NORMAL	ABNORMAL	COMMENTS
Head, Face, Scalp, Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neck, Nodes, Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes, Ears, Nose, Sinuses	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mouth and Teeth	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pharynx and Tonsils	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs and Chest	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abdomen, Hernia, Scars	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genitalia and Rectum (if indicated)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Extremities	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spine and Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological Reflexes	<input type="checkbox"/>	<input type="checkbox"/>	_____

**TEST AND IMMUNIZATIONS**

Dates of immunizations must be specified and reports of all labs and titers must be attached.

The following blood tests are **MANDATORY**

- 1. Varicella Titer Date \_\_\_\_\_ Titer \_\_\_\_\_ Varivax 1 Date \_\_\_\_\_
- 2. VDRL (within 1 year) Date \_\_\_\_\_ Titer \_\_\_\_\_ Varivax 2 Date \_\_\_\_\_

The following requirements may be satisfied by EITHER titers OR documentation of two (2) MMR immunizations (after age 1 year)

- 3. Measles Titer Date \_\_\_\_\_ Titer \_\_\_\_\_ MMR #1 Date \_\_\_\_\_
- 4. Mumps Titer Date \_\_\_\_\_ Titer \_\_\_\_\_ MMR #2 Date \_\_\_\_\_
- 5. Rubella Titer Date \_\_\_\_\_ Titer \_\_\_\_\_

The dates of each of the following must be specified

- 6. Poliomyelitis (Completed series or last booster) Date \_\_\_\_\_
- 7. Tetanus/Diphtheria (within 10 years) Date \_\_\_\_\_
- 8. Hepatitis B vaccine dates 1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_  
3<sup>rd</sup> \_\_\_\_\_

If immune Hepatitis B Surface AB Titer \_\_\_\_\_

- 9. Tuberculin Skin Test (within 1 year) Date \_\_\_\_\_ Result \_\_\_\_\_
- 10. If the Tuberculin Skin Test is known to be positive, a chest x-ray is required within the past 6 months.  
Date \_\_\_\_\_ Result \_\_\_\_\_
- 11. Meningitis Vaccine (within 10 years) Date \_\_\_\_\_

If for some reasons this student is unable to take immunizations, please explain. \_\_\_\_\_

**SUMMARY OF PHYSICAL EXAMINATION**

Physician's name (please print) \_\_\_\_\_

Address \_\_\_\_\_ Telephone ( ) \_\_\_\_\_ - \_\_\_\_\_

Physician's signature \_\_\_\_\_ Date of Examination \_\_\_\_\_

PLEASE RETURN COMPLETED FORM TO: LSUHSC Student Health Services  
2020 Gravier Street  
New Orleans, LA 70112