CROSS ENROLLMENT FORM
SLCC STUDENTS ENROLLING CONCURRENTLY AT UL-LAFAYETTE

NAME (last, first, middle/maiden – one letter per block – one block between names)

SOCIAL SECURITY NUMBER

SEX: ______ MALE ______ FEMALE

BIRTH DATE

COUNTRY OF CITIZENSHIP: Date of High School Graduation:

LOCAL TELEPHONE NUMBER

E-MAIL ADDRESS: PARISH OF H.S. GRADUATION: ____________

LOCAL MAILING ADDRESS: P.O. BOX, STREET NO & NAME, APT. NO.

CITY

STATE

PARISH

ZIP CODE

WHAT IS YOUR ETHNICITY? (you must indicate one ethnicity category)

☐ Hispanic or Latino
☐ Not Hispanic or Latino

MARK ONE OR MORE OF THE FOLLOWING CATEGORIES THAT INDICATE YOUR RACE. (you must indicate at least one race category)

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

TERM FOR WHICH YOU WISH TO REGISTER: 0 Fall 0 Spring 0 Summer YEAR: 20___

YEAR CLASSIFICATION 0 FRESHMAN 0 SOPHOMORE 0 JUNIOR 0 SENIOR 0 GRADUATE

HAVE YOU PREVIOUSLY ATTENDED UL-LAFAYETTE 0 YES 0 NO

IF YES, GIVE FIRST SEMESTER ENROLLED AND LAST SEMESTER ENROLLED

ARE YOU A CANDIDATE FOR A DEGREE AT SLCC THIS SEMESTER? 0 YES 0 NO

NUMBER OF HOURS COMPLETED AT SLCC__________

ARE YOU CURRENTLY RECEIVING FINANCIAL AID? 0 YES 0 NO

COURSES SCHEDULED AT SLCC IN SEMESTER SEEKING CROSS-ENROLLMENT

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Effective 09/11
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BY SIGNING THIS FORM, THE STUDENT ACCEPTS RESPONSIBILITY FOR ASSURING THAT S/HE MEETS ALL PREREQUISITES FOR THE COURSE(S) APPROVED FOR CROSS-ENROLLMENT. THE SIGNATURES OF THE ADVISOR AND REGISTRAR BELOW DO NOT VERIFY THAT THESE COURSES ARE APPLICABLE TO A DEGREE AT SLCC.

THE CROSS ENROLLMENT REQUEST REFLECTED IN THIS DOCUMENT IS IN ACCORDANCE WITH THE CROSS ENROLLMENT AGREEMENT BETWEEN SLCC AND UL-LAFAYETTE. I AUTHORIZE UL-LAFAYETTE TO FURNISH A COPY OF MY FINAL GRADES TO SLCC FOR PURPOSES OF POSTING TO MY PERMANENT ACADEMIC RECORD AT THE END OF THE TERM. I UNDERSTAND THAT (AFTER THE FINAL EXAM PERIOD), I MUST MAKE A WRITTEN REQUEST OF UL-LAFAYETTE FOR THE OFFICIAL TRANSCRIPT TO BE RELEASED TO SLCC.

STUDENT'S SIGNATURE ___________________________ DATE __________

THE ABOVE NAMED STUDENT HAS PERMISSION TO ENROLL IN THE COURSE(S) LISTED ON THIS FORM AS A CROSS-ENROLLED STUDENT FOR THE SEMESTER REQUESTED

SLCC APPROVAL:

SIGNATURE OF ADVISOR ___________________________ DATE __________

SIGNATURE OF REGISTRAR OR REGISTRATION OFFICIAL ___________________________ DATE __________

UL-LAFAYETTE APPROVAL:

SIGNATURE OF REGISTRAR OR REGISTRATION OFFICIAL ___________________________ DATE __________

Effective 09/11
**PROOF OF IMMUNIZATION COMPLIANCE**

Please return the completed form to: University of Louisiana at Lafayette; Student Health Service: PO Box 43692, Lafayette, LA 70504-3692, Fax: 337-482-1872

Name: ___________________________ Date of Birth: ___________ CLID/SSN: __________________

(First/Given) (Last/Family)

When do you plan to start at UL Lafayette: ___________ Month ______ Year

Email: ___________________________ Telephone: __________________

**Instructions:** Immunization requirements are applicable ONLY to students born on or after January 1, 1957. Sections A (and/or B) 
& C must be completed. You must either have a physician or health care provider complete Section A or submit the Universal Certificate of Immunizations provided by the Department of Health and Hospitals, Office of Public Health. **No other attachments or photocopies accepted.** If you have not been immunized for all required diseases, you may request an exemption by completing Section B. However, Section C cannot be waived and must be completed.

**IMPORTANT**: Failure to complete AND turn in this form will PREVENT you from being able to schedule classes.

### Section A: Documentation of Immunizations

1. **MMR (MEASLES, MUMPS, RUBELLA)**
   (Two Doses Required)
   - Date of 1st dose: __________________
   - Date of 2nd dose: __________________

2. **TETANUS**
   (One Dose Required Within 10 years)
   - Date: __________________
   - Vaccine type: __________________

3. **MENINGITIS**
   (One Dose of meningococcal vaccine)
   - Date: __________________
   - Vaccine type: __________________

**AND**

**MEASLES**
   (Two Doses Required)
   - Date of 1st dose: __________________
   - Date of 2nd dose: __________________

**MUMPS**
   (At least One Dose Required)
   - Date: __________________

**RUBELLA**
   (At least One Dose Required)
   - Date: __________________

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**Physician or Health Care Provider Stamp Here**

**Signature of Physician or Health Care Provider**

Address

City, State, Zip

Date ___________ Telephone ___________

### Section B: Immunization Exemption Request

**Instructions:** Only complete Section B if you are choosing not to be vaccinated. Otherwise, please disregard.

I have chosen not to be vaccinated for and am requesting an exemption from one or more of the vaccination(s) listed in **Section A: Documentation of Immunizations**, and I am aware of the risks.

**Vaccination(s) for which I am requesting exemption:**

**Reason for Immunization Exemption Request (please check one):**

- [ ] Medical
- [ ] Personal
- [ ] Shortage (unable to locate vaccine)
- [ ] Other: __________________

I understand that if I claim an exemption for personal or medical reasons, I may be excluded from campus and from classes in the event of an outbreak of measles, mumps, rubella, or meningitis until the outbreak is over or until I submit proof of immunization. I have reviewed information regarding vaccine-preventable diseases and related vaccinations contained on the website for the Center for Disease Control and Prevention (CDC): [http://www.cdc.gov/vaccines/hcp/vis/index.html](http://www.cdc.gov/vaccines/hcp/vis/index.html). If I am not 18 years of age or older, my parent or legal guardian must also sign below.

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**Student Signature**

**Date**

**Parent Signature**

(for students under 18 years old)

**Date**
PROOF OF IMMUNIZATION COMPLIANCE

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PO Box 43692, Lafayette, LA 70504-3692, Fax: 337-482-1872

Name: ________________________________ (Last/Family) Date of Birth: ____________ CLID/SSN: ____________

(First/Given)

Country of Origin: ____________________________ (Do NOT leave blank)

Section C: Tuberculosis (TB) Screening and Targeted Testing

Instructions: Complete all questions in Section C, Part I.

• If the answer is NO to ALL questions, no further testing or action is required.
• If the answer is YES to any of the below questions, you are required to have your physician or health care provider complete Section C, Part II.

You are required to have a tuberculosis skin test (PPD). You may use record of a previous PPD skin test if it was within the last 12 months. PPD skin tests can be obtained from your physician or walk-in clinic.

**IMPORTANT**: Failure to complete AND turn in this form will PREVENT you from being able to schedule classes.

Section C Part I: Tuberculosis (TB) Screening

1. Have you ever had close contact with persons known or suspected to have active TB disease? □ yes □ no

2. Were you born in, have you ever lived in, or recently traveled (within the past 5 years for 2 hours or more) to a high risk country? □ yes □ no

   Africa, Asia, Caribbean nations, Central America (including Mexico), Eastern Europe, India
   and other Indian Subcontinent Nations, Middle East, Portugal, South America, South
   Pacific (except Australia and New Zealand) or Spain

3. Have you ever had a BCG (Tuberculosis vaccination)? If yes, date/year: ____________________________ □ yes □ no

Section C Part II: Tuberculosis (TB) Targeted Testing

Instructions: Section C, Part II to be completed only if there is a YES answer to any questions from Section C, Part I. Section C, Part II to be completed by physician or health care provider ONLY.

Clinical Assessment by HealthCare Provider

• Please review and verify the 3 questions from Section C, Part I completed by student.

• Persons answering YES to any of the questions in Section C, Part I are required to have a Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented.

• Refer to www.cdc.gov for interpretation of TST results:

  o If TST is positive: IGRA is required
  o If IGRA is positive: refer to public health

• Results:

  o TST (results should be based on actual millimeters (mm) of induration; if none, write "0 mm")

    • Date applied: ___________ Date read: ___________

    • mm of induration: ________ Interpretation: (circle one) positive or negative

  o IGRA

    • Date obtained: __________ Method: (circle or fill in blank) QFT-GIT or T-Spot or Other___________

    • Result: (circle one) negative or positive or indeterminate or borderline (T-Spot only)

• Assessment (please check)

  _______ TST is negative: no further action is required.
  _______ TST is positive and IGRA is negative: no further action is required.
  _______ TST is positive and IGRA is positive: refer to public health (please specify).

*Please notify patient that a letter from public health must be received in order to gain clearance for entrance to campus.

Signature of Physician or Health Care Provider

Address

City, State, Zip

Date Telephone

Physician or Health Care Provider Stamp Here