South Louisiana Community College

Cross-Enrollment Form

Student Information

Last Name

First Name
Middle

Social Security Number

Student ID # (LoLA)

Phone Number

Date of Birth (month/date/year)

E-mail Address

Mailing Address

City

State

Zip Code

Parish

High School: graduation date (month/year): _____ / _____ parish: _____

Indicate your country of citizenship. _____

Indicate your ethnicity. (Applicants must select ONE category.)

☐ Hispanic or Latino/a ☐ Not Hispanic or Latino/a ☐ Prefer Not to Indicate

Indicate your race. (Applicants must select AT LEAST ONE category.)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Prefer Not to Indicate

Indicate your sex. ☐ Female ☐ Male

Indicate your class standing. ☐ Freshman ☐ Sophomore

Indicate your first semester at SLCC. ☐ Fall ☐ Spring ☐ Summer ☐ Year _____

Indicate your most-recent semester at SLCC. ☐ Fall ☐ Spring ☐ Summer ☐ Year _____

Indicate your number of credits earned at SLCC. _____ credits

Have you or will you apply for graduation this semester? ☐ Yes ☐ No

Do you currently receive financial aid? ☐ Yes ☐ No

Cross-Enrollment Form

Course Information

Last Name: _____ First Name: _____

Do you meet the minimum 2.25 cumulative GPA requirement for cross-enrollment? ☐ Yes ☐ No

Indicate the semester for which you request to cross-enroll.

☐ Fall ☐ Spring ☐ Summer ☐ Other _____ ☐ Year _____

Indicate the course(s) in which you request to cross-enroll.

CRN (e.g., 10001)	**Course Number** (e.g., ARTS 1001)	**Course Title** (e.g., Intro to Visual Arts)	**Days & Times** (e.g., MW, 2-3:15 pm)	**Credits** (e.g., 3)

Student Acknowledgement of Academic Responsibility

I acknowledge my responsibility for selecting courses at the University of Louisiana at Lafayette (ULL) and for meeting all prerequisites and corequisites for the course(s) indicated above. I further acknowledge my responsibility to understand and to comply with all South Louisiana Community College (SLCC) and ULL policies, procedures, and deadlines relevant to my registration, enrollment, and student account. These include SLCC's add/drop, withdrawal, and refund policies.

Student Acknowledgement of Financial Obligations

I acknowledge my obligation to pay all tuition, fees, and associated charges for the course(s) indicated above at the time of my registration. I further acknowledge that the SLCC student accounts office requires me to meet my financial obligations by applicable deadlines. I understand that failure to do so will result in further action to collect the balance due. This may include the transfer of the balance due to the State of Louisiana's Office of Attorney General for collection. If my account is transferred for collection, I am responsible for all collection charges, including, but not limited to, attorney fees and court costs.

Student Acknowledgement of Cross-Enrollment Registration

I authorize the South Louisiana Community College (SLCC) registrar's office to register me for the course(s) indicated above at the University of Louisiana at Lafayette (ULL) in the semester indicated above.

Student Acknowledgement of Academic Records Release

I authorize SLCC to access my academic record from University of Louisiana at Lafayette (ULL). I authorize SLCC and ULL to exchange my academic information, including but not limited to, my transcript and registration information, for any purpose related to my eligibility or participation in this program. I understand that ULL will furnish a copy of my official grades and/or transcript to SLCC for purposes of posting to my permanent academic record at SLCC.

_____ _____

Student's Signature Date (month/day/year)

Instructor Name: _____

Dean's Acknowledgement of Review

I acknowledge reviewing SLCC's cross-enrollment policies and procedures with the student indicated above.

☐ Student is aware of credit(s) that may transfer. ☐ Student is aware of credit(s) that may not transfer.

_____ _____

Dean's Signature Date (month/day/year)

For Office Use Only

☐ Verified GPA ☐ Emailed Student ☐ Contacted ULL

Date: _____

Processed by: _____

RONF042024

PROOF OF IMMUNIZATION COMPLIANCE

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

Student Health Services: P.O. Box 43692 · Lafayette, LA 70504-3692 · Phone: 337-482-1293 · Fax: 337-482-1872

You must either have a physician or health care provider complete documentation of Immunizations, or submit the Universal Certificate of Immunizations provided by Louisiana Department of Health, Office of Public Health. If you have not been immunized for all of the required diseases, you may request an exemption by completing the Exemption Request form. The Tuberculosis Screening Questionnaire cannot be waived and must be completed.

STUDENT COMPLETES

Name: _____ **ULID:** _____

Address: _____ **Start Term:** _____

Date of Birth: _____ **Phone:** _____ **Email:** _____

Enrollment Status: (Check ALL that apply)

□ Undergraduate □ Graduate Student □ Re-entry Student

□ Transfer Student □ Dual Enrollment Student □ Online Student

Class:

□ **Freshman** □ **Junior**

□ **Sophomore** □ **Senior**

REQUIRED IMMUNIZATIONS

MUST BE COMPLETED, SIGNED AND STAMPED BY HEALTHCARE PROVIDER

MMR (Measles, Mumps and Rubella)

Two doses at least 28 days apart. First dose after 12 months of age. May submit titers for proof of immunization.

First Dose: _____ or Titer: _____ (Provide copy of Results)

Second Dose: _____ Results:_____

MENINGITIS

One dose at 16 years of age or older.

Quadrivalent Vaccine A, C, Y, W-135

Last Dose: _____

Choose one: □ Menactra □ Menveo

TETANUS

One of below doses.

Must be within the last 10 years.

Last Dose: _____

Choose one: □ TD □ TDAP

COVID- 19

One dose of Johnson & Johnson (Janssen) or Two doses of Moderna at least 28 days apart or Two doses of Pfizer at least 21 days apart or Other COVID vaccination that must be FDA or WHO approved.

1st Dose: _____

2nd Dose: _____

Type : ☐ Johnson & Johnson

☐ Moderna

☐ Pfizer

☐ Other FDA or WHO approved vaccine

_____

Provider Signature

_____

Address

_____

City, State, Zip

_____

Phone Date

Provider Stamp Here

Refer to Student Health Services website: https://studenthealth.louisiana.edu/ for instructions on how to submit forms and for information on LDH requirements: https://lalinks.org/linksweb/docs/Higher_Learning_Immunization_Requirements_March2020.pdf.

Please upload the completed form to the Patient Portal at ***ull.medicatconnect.com***

EXEMPTION FROM IMMUNIZATIONS DECLARATION

Student Health Services • P.O. Box 43692 Lafayette, LA 70504-3692
Phone: (337) 482-1293 Fax: (337) 482-1872

Name: _____ **Date of Birth: _____**

ULID: _____ **Semester/Year Enrollment: _____**

UL Lafayette email: _____ **Phone: (_____)_____**

I am requesting an exemption from one or more of the following vaccinations and I am aware of the risks (check all that apply):

□ **MMR 1st dose** □ **MMR 2nd dose** □ **TETANUS** □ **MENINGITIS**

□ **COVID-19 1st dose** □ **COVID-19 2nd dose**

Reason for exemption for the above-referenced immunization(s):

□ Medical - If a medical exemption is declared, Student must return the completed Vaccine Exemption Physician Certification Form (attached) to Student Health Services at Patient Portal at ***ull.medicatconnect.com***.

□ Personal/Philosophical - If this exemption is requested, state the reason: _____
_____
_____

Understand the Risks and Responsibilities

Pursuant to Louisiana R.S. § 17:170: In the event of an outbreak of a vaccine-preventable disease at University of Louisiana at Lafayette, the administrators are empowered, upon the recommendation of the Louisiana Office of Public Health, to exclude from attendance unimmunized students until the appropriate disease incubation period has expired or the unimmunized person presents evidence of immunization.

By signing below, I understand that if I declare an exemption, I may be excluded from campus and from classes in the event of an outbreak until the outbreak is over or until I submit proof of immunizations. I understand that if I decline any of the required vaccinations, I continue to be at risk for serious disease. I can always receive the vaccine(s) at any time. I have read and understand the vaccine information from the Louisiana Office of Public Health and the Centers for Disease Control and Prevention and understand risks and responsibilities in exempting/declining the required immunizations.

Student Signature: SIGN HERE _____ **Date: _____**

If student is not 18 years of age, legal guardian must sign below.

Parent or Guardian Signature (if required): _____ **Date: _____**

Please upload the completed form to the Patient Portal at ull.medicatconnect.com

Find FAQs regarding this form at https://studenthealth.louisiana.edu/immunizations/immunization-compliance-faqs

Vaccine Exemption Physician Certification

I am a physician licensed to practice medicine in a jurisdiction of the United States. By signing below, I certify that for _____ (patient name), the following vaccine(s) is(are) contraindicated for medical reasons (check all that apply):

□ **MMR 1st dose** □ **MMR 2nd dose** □ **TETANUS** □ **MENINGITIS**

□ **COVID-19 1st dose** □ **COVID-19 2nd dose**

The contraindication(s) is(are): □ Permanent □ Temporary

If temporary, the contraindication is expected to preclude immunizations until: Date _____

Physician Information

Physician Signature: _____ Date: _____

Physician Name: _____

Physician Specialty: _____

Physician License Number: _____

Name of Physician Company: _____

Address: _____

Email: _____ Phone: _____

PLEASE READ ENTIRE FORM CAREFULLY!

TUBERCULOSIS SCREENING QUESTIONNAIRE

(To be completed by ALL Students BEFORE registration at UL Lafayette)

THIS FORM CANNOT BE WAIVED!

FAILURE TO COMPLETE THIS FORM AND SUBMIT TO STUDENT HEALTH SERVICES WILL RESULT IN AN IMMUNIZATION HOLD ON YOUR ACCOUNT AND WILL PREVENT YOU FROM REGISTERING FOR CLASSES

Student Health Services : P.O. Box 43692, Lafayette, LA 70504-3692 • Phone: 337-482-1293 • Fax: 337-482-1872 • Email: immunizations@louisiana.edu

Name : _____ **DOB:** _____ **ULID:** _____

ABOUT THIS FORM:
- UL Lafayette requires **ALL enrolled students** complete the Tuberculosis Screening Questionnaire that assesses the risk of TB infection and disease. This aids in the prevention and control of Tuberculosis on campus.
- If your Tuberculosis Screening Questionnaire is POSITIVE (answering YES to any of the questions below), further testing is required. This can be a lengthy process. To avoid delays in receiving your I-20 and/or being able to enroll in your preferred classes, complete this screening as soon as you are able.
- Answer the questions on this screening completely and accurately. Misrepresentation of information could jeopardize your health and the health of others.
- If you are under 18 or if you are unsure how to complete the questionnaire, a parent or guardian may be able to assist you.

*Please answer **YES** or **NO** to the following questions:*

1. Have you ever had close contact with persons known or suspected to have active Tuberculosis disease? **Yes** **No**

2. Were you born in one of the countries or territories listed BELOW that have a high incidence of active TB disease? **Yes** **No**

If **YES**, please **CIRCLE** the country below.

Angola	Cambodia	Ethiopia	Kenya	Moldova	Papua New Guinea	South Africa	Ukraine
Azerbaijan	Cameroon	Ghana	Korea	Mozambique	Peru	Swaziland	Uzbekistan
Bangladesh	Central African Republic	Guinea-Bissau	Kyrgyzstan	Myanmar	Philippines	Tajikistan	Viet Nam
Belarus	Chad	India	Lesotho	Namibia	Russian Federation	Tanzania	Zambia
Botswana	China	Indonesia	Liberia	Nigeria	Sierra Leone	Thailand	Zimbabwe
Brazil	Congo	Kazakhstan	Malawi	Pakistan	Somalia	Uganda	

3. In the last 5 years, have you visited one or more of the countries or territories listed above with a high prevalence of TB disease? (If YES, please CHECK the countries or territories, above) **Yes** **No**

4. Have you been a resident and/or employee of high risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? **Yes** **No**

5. Have you been a volunteer or health care worker who served clients who are at increased risk of active TB disease? **Yes** **No**

6. Have you ever been a member of any of the following groups that may have an increased incidence in latent M. tuberculosis infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol? **Yes** **No**

Source: World Health Organization Global Health observatory, Tuberculosis Incidence 2019. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to : http://www.who.int/tb/country/en/. UL Lafayette follows the screening guidelines of the American College Health Association (www.acha.org) and the US Center for Disease Control (www.cdc.gov/tb/publications/factsheets/default.htm).

If the answer to **ALL** of the above questions is **NO**, no further testing or action is required except to turn form in to SHS.

If the answer is **YES** to ANY of the questions above, you will be required to undergo further evaluation including a TB Skin Test (TST/PPD) or blood test prior to beginning class. Have your health care provider complete the attached TB Risk Assessment and testing form and return it to Student Health Services. (Documentation of a negative TB Test obtained in the past year may be accepted.) Appropriate documentation includes:

1. PPD (Mantoux) Skin test read and documented in millimeters of induration or IGRA blood test results. Both must be within the last 12 months.
2. If you have received treatment for active TB disease, you will need to provide proper documentation of treatment to Student Health Services prior to attending class.

Turn completed form into Student Health Services by mail, via fax, in person, or email to: immunizations@louisiana.edu prior to the start of school. This questionnaire can also be answered electronically via the patient portal. Patient portal is accessable through ULINK using your ULID and password. Any detailed information about how to complete this form or, how to get follow up testing can be explained via email or at Student Health Services.