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 the 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 Authorization for 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 (UL Lafayette) in the semester indicated above.

______________________________ ______________________

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

Advisor Acknowledgment 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.

______________________________ ______________________

Advisor's Signature Date (month/date/year)

For Office Use Only Date ______________________

☐ Verified GPA ☐ Emailed Student ☐ Contacted ULL Processed by ______________________

UNIVERSITY of LOUISIANA LAFAYETTE

PROOF OF IMMUNIZATION COMPLIANCE

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

Please return the completed form to: University of Louisiana at Lafayette; Student Health Service:
PO Box 43692, Lafayette, LA 70504-3692, Fax: 337-482-1873

Name: ______________________________ Date of Birth: __________ CLID/SSN: ______________
(Last/Family) (First/Given)

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: ______________________

AND

2. TETANUS
(One Dose Required Within 10 years)

Date: ______________________

Vaccine type: ______________________

AND

3. MENINGITIS
(Two Doses of meningococcal vaccine)

Date: ______________________

Vaccine type: ______________________

(Minimum interval is eight weeks)

Date: ______________________

Vaccine type: ______________________

OR

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: ______________________

____
Signature of Physician or Health Care Provider

____
Address

____
City, State, Zip

______________ ______________
Date Telephone

Physician or Health Care Provider Stamp Here

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. If I am not 18 years of age or older, my parent or legal guardian must also sign below.

______________________ ______________ ______________________ ______________
Student Signature Date Parent Signature (for students under 18 years old) Date

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PO Box 43692, Lafayette, LA 70504-3692, Fax: 337-482-1873

Name: ____ Date of Birth:__________ CLID/SSN:______________
(Last/Family) (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 tuberculin 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, Central America (including Mexico), Eastern Europe, India
   and other Indian Subcontinent Nations, Middle East, Portugal, South America,
   South Pacific (except Australia and New Zealand)
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:
  - If TST is positive: IGRA is required
  - If IGRA is positive: refer to public health
- Results:
  - 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**
  - 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