Dear Student;

On behalf of the staff of Student Health Services, welcome to Xavier University of Louisiana. Xavier University and Louisiana state law requires that all students residing on campus or off campus to submit vaccination documentation.

Directions for completion of the Immunization Compliance & Consent for Care Forms

- Page 1 is required for all individuals who will be attending the university.
- Page 1 must be completed, signed and stamped by the student’s physician or medical provider.
- Only state computer generated printouts of previous vaccines will be accepted without a physician signature. NO EXCEPTIONS!!!
- Page 2 (Consent for Care/ Emergency Treatment Form) must be completed and signed by a parent or legal guardian for those students that are 17 years of age or younger.
- Mail or Fax completed form to:  
  [Student Health Services]  
  1Drexel Drive – Box 36 
  New Orleans, La. 70125  
  FAX: (504)520-7962

Required Immunizations

Measles, Mumps, Rubella (MMR) requirement: Two (2) doses of live vaccine required for all participants born after 1956. The first vaccine must have been given, on or after the first birthday and a second dose at least 30 days after the 1st dose.

Tetanus-Diphtheria- Pertussis (Td, Tdap): One (1) dose of vaccine given within the past ten (10) years. NOTE: (Tdap) is recommended.

Meningococcal Meningitis Vaccine: One (1) dose of vaccine given within the past five (5) years for those participants 54 years of age or younger.

Tuberculosis (TB) Skin Test: Must be within six (6) months of registration.

Recommended Immunizations

Varicella: Two (2) doses.

Students Residing on Campus

Students residing on campus must submit all required immunizations before Residence hall check in.

If further information regarding immunizations is required please contact Student Health Services @ (504)520-7396. Avoid delay in registration and submit your completed Immunization Compliance /Consent as soon as possible.
XAVIER UNIVERSITY OF LOUISIANA

Proof of Immunization Compliance

(Louisiana R.S. 17:170 Schools of Higher Learning)
(Louisiana ACT 251and 711)

STUDENT COMPLETES

Student ID#__________________________ (or SSN #) Fall___Spring___Summer___20_________

Name: ___________________________ ____________________________

LAST FIRST MIDDLE

Birth Date: _________/_________/___________ Age: _______ Sex: _______ On Campus____ Off Campus

Home Address: ____________________________________________________________
P.O. BOX / STREET CITY STATE ZIPCODE

Home Phone: ( ) __________________________ Email Address: ____________________________

Cellular Phone: ( ) __________________________

MUST BE COMPLETED AND SIGNED BY HEALTHCARE PROVIDER

PPD (MANTOUX) SKIN TEST / TUBERCULOSIS TESTING - PPD NEEDS TO BE DONE WITHIN SIX MONTHS OF REGISTRATION. History of BCG Vaccination does not eliminate the PPD requirement.

PPD Date applied: _________/_________/_________ Site of injection _________ Lot # __________ Manufacturer______________

Date read: _________/_________/_________ Result: ________ mm of induration Interpretation: Positive ______ Negative ______

New Converters: ( Copy of Chest X-ray report required if PPD test is positive)

NOTE*** HISTORY OF POSITIVE PPD SKIN TEST: Have your M.D. send a statement documenting the date of positive PPD test, date of last chest x-ray and present health status.

__________________________________________________

HEALTH CARE PROVIDER SIGNATURE DATE

HEALTHCARE PROVIDER STAMP

HEALTH CARE PROVIDER STREET ADDRESS

__________________________________________________

CITY STATE ZIPCODE

***IF BORN PRIOR TO 1957, MEASLES VACCINE IS NOT REQUIRED*** MEASLES DOSE #1 12-15 MONTHS AFTER BIRTH

MMR1 DATE MMR2 DATE

OR

MEASLES (RUBEOLA) DOSE 1 DATE

DOSE 2 DATE

MUMPS DATE RUBELLA DATE

OR

COPY OF SEROLOGIC TEST

TD, T-dap Within 10Yrs. MENINGITIS Within 5Yrs. 55Yrs. or older vaccine not required

DATE DATE

DATE

RECOMMENDED IMMUNIZATION(S)

VARICELLA: #1________________ #2 __________________

HEALTHCARE PROVIDER SIGNATURE DATE

HEALTHCARE PROVIDER ADDRESS PROVIDER TELEPHONE #

Mail or Fax Completed Form to: Student Health Services > 1 Drexel Drive – Box 36, New Orleans, La. 70125 Fax: (504)520-7962

O
CONSENT FOR CARE/EMERGENCY TREATMENT
FOR ALL STUDENTS 17YRS. OR YOUNGER PARTICIPATING IN
UNIVERSITY AFFILIATED PROGRAMS.

I understand that in accordance with Xavier University of Louisiana Policy a signed consent form from a parent or legal guardian must be on file at the University Health Services Center before providing treatment to minors who are attending or participating in University affiliated programs.

In that regard, I hereby request and authorize the Xavier University Student Health Services Center to provide: _______________________________________________________     ______________________

(Print) Student/Participant Name     Date of Birth

to receive health care services available and deemed necessary by the staff of the Xavier University Health Services Center. These services may include, but are not limited to, such procedures as evaluation and treatment of acute illnesses and injuries. Consent is specifically given for care in the event the above named minor student/participant presents him/herself for treatment in my absence. I also consent to Xavier University Health Services Center staff contacting any such persons or agencies for the purpose of providing or receiving information and records necessary for the care of the aforementioned minor student and will sign any necessary forms in that regard.

This Consent for Care is authorized for the length of time the participant is enrolled in the University. I may choose to withdraw the consent at any time by contacting Xavier University of Louisiana Student Health Services Center in writing. My permission is hereby given to Xavier University of Louisiana, through its appointed representative(s) to use discretion in providing, at my expense (personal / insurance, etc.) emergency care.

Parent/Guardian’s Name (Print): ______________________________________________________

Last   First   MI

Parent/Guardian’s Signature: ______________________________________________________

Last   First   MI   Date

Home Phone: (        ) _______________________ Cellular Phone: (        ) ___________________________

EMERGENCY CONTACT INFORMATION

Name (Print): ______________________________________________________

Last   First   MI   Relationship

Home Phone: (        ) _______________________ Cellular Phone: (        ) _________________________