



Office of Student Health Services  
1 Drexel Drive – Box 36  
New Orleans, La.70125

Office: (504) 520-7396  
Fax: (504) 520-7962

Dear Student;

Louisiana Law (R.S.17:170) Schools of higher learning requires all **students** entering Xavier University of Louisiana to submit the required immunizations listed below.

Returning students will be required to update those immunizations that are outdated. Please contact Student Health Services @ (504)520-7396 to confirm which immunizations you will need to update.

**Directions for completion of the Required Immunizations & Consent for Care Form**

- **Page 1** is required for all individuals with the exception of **on-line** students who will not be attending classes on campus.
- **Page 1** must be **completed, signed and stamped** by the student's physician/medical provider.
- Only state computer generated printouts of previous vaccines will be accepted without a physician signature and clinic stamp. **NO EXCEPTIONS!!!**
- **Page 2 (Consent for Care Form)** must be completed and signed by a parent or legal guardian for those students that are 17 years of age or younger.
- Please have the required immunization form completed and return prior to registration. Failure to do so will result in your registration being delayed.
- This information may be returned in person, mailed or faxed to:

**Physical Location**  
St. Joseph Academic & Health  
Resource Center 2<sup>nd</sup> floor - 217  
Office: (504)520-7396

**Mailing Address**  
Xavier University of LA  
Student Health Services  
1 Drexel Drive - Box 36  
New Orleans, LA 70125

**Fax Number**  
(504) 520-7962

**Required Immunizations**

**Measles, Mumps, Rubella (MMR) requirement:** Two (2) doses of live vaccine required at least 28 days apart, 1<sup>st</sup> MMR dose must be given on or after the first birthday. If born prior to 1957, vaccine not required. Documentation of immunity by serologic test is also acceptable.

**Tetanus-Diphtheria-Pertussis (Td, T-dap)** One (1) dose of vaccine given within the past ten (10) years.

**Meningococcal Meningitis (Quadrivalent vaccine A, C, Y, W-135):** One (1) dose required at 16 years of age or older. Not required for those 55yrs.or older.

**Tuberculosis Questionnaire:** All students entering the university must complete the tuberculosis questionnaire (Tb).

**Recommended Immunizations**

**Hepatitis B Vaccine:** Three (3) doses

**Varicella:** Two (2) doses.



# XAVIER

UNIVERSITY of LOUISIANA

Office of Student Health Services  
1 Drexel Drive – Box 36  
New Orleans, La.70125

## Required Immunizations (Louisiana State Legislature R.S.17:170) Schools of Higher Learning

<b>STUDENT COMPLETES</b>	Student ID# _____ (or SSN #) _____	Fall _____ Spring _____ Summer _____ 20 _____
	Name: _____	_____
	Birth Date: _____ / _____ / _____	Age: _____ Sex: _____ On Campus _____ Off Campus _____
	Home Address _____	_____
	P.O. BOX / STREET _____ CITY _____ STATE _____ ZIPCODE _____	
	Home Phone : ( ) _____ Cellular Phone: ( ) _____ E-mail: _____	

<b>MUST BE COMPLETED, SIGNED &amp; STAMPED BY HEALTHCARE PROVIDER</b>	Two (2) doses of MMR required at least 28 days apart. 1 <sup>st</sup> dose after 12 months of age. If born prior to 1957 vaccine not required.	<b>TD, T-dap</b> Dose must be within last 10 years. (T-dap recommended)	<b>MENINGITIS</b> (Quadrivalent vaccine A, C, Y, W-135) One (1) dose required at 16yrs. of age or older. 55yrs. or older vaccine not required.	
	MMR#1 _____ DATE _____	MMR#2 _____ DATE _____	_____ DATE _____	_____ DATE _____
		OR		
	MEASLES (RUBEOLA) #1 _____ DATE _____			
		#2 _____ DATE _____		
	MUMPS _____ DATE _____	RUBELLA _____ DATE _____		
	OR			
	<b>COPY OF SEROLOGIC TEST (Titers)</b>	<b>RECOMMENDED IMMUNIZATION(S)</b>		
		<b>VARICELLA (2 DOSES)</b>		
		VARICELLA#1 _____ DATE _____	VARICELLA#2 _____ DATE _____	
		<b>HEPATITIS B (3 DOSES)</b>		
		HEPATITIS#1 _____ DATE _____	HEPATITIS#2 _____ DATE _____	
		HEPATITIS#3 _____ DATE _____		

Provider Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_ Phone#: ( ) \_\_\_\_\_

**CLINIC STAMP**

**Tuberculosis (TB) Questionnaire (Please answer the questions below)**

Have you ever had a positive TB skin test, if yes **STOP** here: Have your physician send a statement documenting the date of positive Tb test, copy of last chest x-ray or IGRA report and your present health status.

1. Have you ever had close contact with somebody ill with TB?  Yes  No
2. Have you visited Africa, East Europe, Asia, Middle East or South/Central America in the last six months?  Yes  No
3. Have you been an employee / volunteer in a prison, nursing home, homeless shelter or hospital in the last six months?  Yes  No
4. Do you take immunosuppressive medications that suppress the immune system?  Yes  No
5. Do you have AIDS/HIV?  Yes  No

**If the answer to all the above questions is NO, no further action is required.**  
**If the answer is YES to any of the questions 1 – 5, you must obtain Tb testing.**

**Tuberculin Skin Test: (Must be done within 6 months of this registration)**

Date applied: \_\_\_/\_\_\_/\_\_\_ Date read: \_\_\_/\_\_\_/\_\_\_ Injection Site: \_\_\_\_\_ Lot #: \_\_\_\_\_ Manufacturer: \_\_\_\_\_

Result: \_\_\_\_\_ mm of induration Interpretation: Negative \_\_\_\_ Positive \_\_\_\_ (IGRA is required if PPD is positive; if IGRA is positive a Chest X-ray is required)

**PPD Interpretation Guideline**

≥ 5 mm is positive: Recent close contact with person with active TB, Abnormal CXR c/w past TB disease, Organ transplant or other immunosuppression illicit drug use HIV/AIDS

≥10 mm is positive: Significant travel or residence in high prevalence area, Worker in healthcare, homeless shelter, prisons, Chronic health issues, as per screening questions

≥15 mm is positive if no risk factors

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Provider Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_ Phone#: ( ) \_\_\_\_\_

**CLINIC STAMP**

**CONSENT FOR CARE  
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:

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<b>(Print) Student/Participant Name</b>	<b>ID#</b>	<b>Date of Birth</b>
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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: ( ) \_\_\_\_\_

Name (Print): \_\_\_\_\_  
Last First MI Relationship

Home Phone: ( ) \_\_\_\_\_ Cellular Phone: ( ) \_\_\_\_\_