Dear Summer Program Participant;

On behalf of the staff of Student Health Services, welcome to Xavier University of Louisiana.

Xavier University and Louisiana state law requires that all summer participants’ 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 participating in a summer program.
- **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 participants that are 17 years of age or younger.
- Mail completed form to: Program Director

**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.

**NOTE:** TB Skin test is a 2 – 3 day process and is available in Student Health Services for a fee of $20.00. It is administered on Monday, Tuesday, Wednesday and Friday, during regular clinic hours 8:30AM – 4:30PM – **Appointment not required.**

If further information regarding immunizations is required please call Student Health Services @ (504)520-7396. Avoid delay in registration and send your completed Immunization Compliance /Consent Forms to your program director as soon as possible.

**Remember** ✅ Immunization Compliance Forms without a physician’s or healthcare provider signature will not be accepted.
**Student Completes**

<table>
<thead>
<tr>
<th>Student ID# ____________________________ (or SSN #)</th>
<th>Summer Program Name ____________________________</th>
<th>Summer 20____</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: ________________________________________________________________________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LAST _________________________________________________________________________________________</td>
<td>FIRST _________________________________________________________________________________________</td>
<td>MIDDLE _______________________________________________________________________________________</td>
</tr>
<tr>
<td>Birth Date: _______<em><strong>/<strong><strong><strong><strong>/</strong></strong></strong></strong></strong></em></td>
<td>Age: ______</td>
<td>Sex: ______</td>
</tr>
<tr>
<td>Home Address: ___________________________________________________________________________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>P.O. BOX / STREET _____________________________________________________________________________________</td>
<td>CITY _________________________________________________________________________________________</td>
<td>STATE _____________________________________________________________________________________</td>
</tr>
<tr>
<td>Home Phone: ( ) _____________________________________________________________________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cellular Phone: ( ) _________________________________________________________________________________</td>
<td>Email Address: _______________________________________________________________________________</td>
<td></td>
</tr>
</tbody>
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**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.

<table>
<thead>
<tr>
<th>HEALTH CARE PROVIDER SIGNATURE</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEALTH CARE PROVIDER STREET ADDRESS</td>
<td></td>
</tr>
<tr>
<td>CITY</td>
<td>STATE</td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>MMR1 DATE</th>
<th>MMR2 DATE</th>
</tr>
</thead>
</table>

OR

<table>
<thead>
<tr>
<th>MEASLES (RUBEOLA) DOSE 1 DATE</th>
<th>DOSE 2 DATE</th>
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</thead>
</table>

**TD, T-dap Within 10 Yrs.**

<table>
<thead>
<tr>
<th>TD, T-dap Within 10 Yrs.</th>
<th>MENINGITIS Within 5 Yrs. 55 Yrs. or older vaccine not required</th>
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<tbody>
<tr>
<td>_______________________</td>
<td>_______________________</td>
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</tbody>
</table>

**MUMPS ___________________ RUBELLA ___________________**

**COPY OF SEROLOGIC TEST**

HEALTHCARE PROVIDER SIGNATURE DATE

HEALTHCARE PROVIDER ADDRESS ____________________________ PROVIDER TELEPHONE #
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: (        ) __________  
Last                                       First                      MI   Date