



XAVIER UNIVERSITY OF LOUISIANA STUDENT HEALTH ASSESSMENT FORM

(Type or print in blue or black ink only)

Fall _____ Spring _____ Summer _____ 20 _____

CLASSIFICATION: Fresh _____ Soph _____ Junior _____ Senior _____ Transfer _____ Transient _____

Pharm D. ___ Graduate ___ Drexel ___ Other ___ (Specify) _____

Student ID# _____ (or SSN#) _____

Name: _____

LAST

FIRST

MIDDLE

Birth Date: ____/____/____ Age: ____ Sex: ____ Marital Status: _____

Home Address: _____

P.O. BOX/STREET

CITY

STATE

ZIP CODE

Home Phone () _____ Cellular Phone () _____

E-mail Address: _____

Address while attending Xavier: _____

(List Name of Dormitory, if known)

P.O. BOX/STREET

CITY

STATE

ZIPCODE

Student Contact Phone # while attending Xavier: () _____

Xavier University Medical Insurance Coverage Policy:

All students are required to have medical insurance coverage.

If you are covered by insurance, you may decline to be enrolled in the school's insurance.

Insurance waiver form **MUST** be completed on-line in order to **DECLINE** Student Health Insurance before Posted Deadline.

NO EXCEPTIONS

See xula.edu website for waiver information:

Student Health Services – click on insurance

STUDENTS WITH INSURANCE COVERAGE OF THEIR OWN MUST HAVE A COPY OF THEIR CARD IN CASE OF AN EMERGENCY OR IF THEY NEED TO SEEK MEDICAL CARE OFF CAMPUS.

RETURN FORM TO: Xavier University of Louisiana
Student Health Services – 1 Drexel Drive – Box 36
New Orleans, LA 70125
(504) 520-7396

TO BE COMPLETED BY STUDENT

Allergies (Food/Meds) _____ Weight _____ Height _____

List medicine(s) currently taking _____

Please rate your physical health (as of 90 days) Good _____ Fair _____ Poor _____

CHECK ANY MEDICAL PROBLEM(S) LISTED BELOW THAT YOU HAVE OR HAD:

- | | |
|---------------------------------|-------------------------------------|
| Alcoholism _____ | Gallbladder Disease _____ |
| Arthritis _____ | Gastric Reflux _____ |
| Anorexia Nervosa _____ | Hay Fever _____ |
| Asthma _____ | Hearing Disorder (right/left) _____ |
| Autoimmune Disorder _____ | Heart Disease _____ |
| Back Pain _____ | Hepatitis _____ |
| Bipolar Disorder _____ | High Blood Pressure _____ |
| Bladder Infection _____ | Kidney Problem _____ |
| Blindness _____ | Low Back Pain _____ |
| Bronchitis _____ | Meningitis _____ |
| Bulimia _____ | Menstrual Cramps _____ |
| Cerebral Palsy _____ | Mitral Valve Prolapse _____ |
| Chronic Pain (Specify) _____ | Multiple Sclerosis _____ |
| Colitis _____ | Obesity _____ |
| Connected Tissue Disorder _____ | Paralysis _____ |
| Deafness _____ | Peptic Ulcer _____ |
| Depression _____ | Pneumonia _____ |
| Diabetes _____ | Pregnancy (how many months) _____ |
| Drug/Substance Abuse _____ | Sickle Cell Anemia _____ |
| Effects from injury _____ | Stress _____ |
| Epilepsy _____ | Stroke _____ |
| Fibrocystic Disease _____ | Tuberculosis _____ |

Other (specify) _____

Do you have a permanent physical or mental disability? _____ Yes _____ No.

Please Specify _____

Does the disability require assistive devices, handicap parking, etc? _____ Yes _____ No.

Please Specify _____

Do you wear glasses / contact lenses? _____ Yes _____ No. Do you smoke cigarettes? _____ Yes _____ No

If yes, how many cigarettes per day? _____ or packs per day _____

List any surgeries: _____

STUDENT'S SIGNATURE: _____ DATE: _____

Note: If student is a minor, parent or guardian's signature is required: _____

REQUIRED IMMUNIZATION FORM
(THIS PAGE MUST BE COMPLETED AND SIGNED BY YOUR PHYSICIAN)

Name _____ Student ID _____ DOB ____/____/____
Last First Middle

TB SKIN TEST (MANTOUX): NEEDS TO BE DONE WITHIN SIX MONTHS OF REGISTRATION. TINE TEST IS NOT ACCEPTED: SKIN TEST REQUIRED, REGARDLESS OF PRIOR BCG INOCULATIONS.

Date applies ____/____/____ Site of injection _____ Lot# _____ Manufacturer _____

Date read ____/____/____ Results (mm) _____ (Copy of Chest X-rays required if TB test is Positive).
HISTORY OF POSITIVE TB SKIN TEST: Complete TB interview or have M.D. send a statement documenting health status – No communicable disease.

Health Care Provider's Signature / Official Stamp _____

TETANUS (DPT/TD/DT/Tdap) must be current through anticipated Xavier graduation date.

Date ____/____/____ Lot# _____ Manufacturer _____

HEALTH CARE PROVIDER'S SIGNATURE / OFFICIAL STAMP. _____

***** IF BORN PRIOR TO 1957 – MEASLES VACCINE IS NOT REQUIRED *****
(MEASLES DOSE #1 – 12 – 15 MONTHS AFTER BIRTH – DOSE #2 AFTER 1980)

MMR#1 DOSE ____/____/____ MMR#2 DOSE ____/____/____

OR

MEASLES (RUBEOLA)

1ST DOSE ____/____/____ MUMPS DOSE ____/____/____ RUBELLA DOSE ____/____/____

2ND DOSE ____/____/____ **OR**

Enclose copy of Serologic Results: Measles / Mumps / Rubella

Health Care Provider's Signature/Official Stamp: _____

MENINGOCOCCAL MENINGITIS - Date ____/____/____ (Must be dated no earlier than 2006).

Health Care Provider's Signature/Official Stamp: _____

If Entering the College of Pharmacy additional *Required* Immunizations listed below

Hepatitis B: Three Doses Required

VARICELLA: Two Doses Required

Dates: #1 ____/____/____
#2 ____/____/____
#3 ____/____/____

#1 ____/____/____
#2 ____/____/____

Health Care Provider's Signature/Official Stamp: _____

(OR) Enclose copy of Serologic Results



**XAVIER UNIVERSITY OF LOUISIANA
HEALTH SERVICE – HEALTH ASSESMENT FORM
CONSENT FOR EMERGENCY TREATMENT**

In case of an emergency whereby you are unable to personally give consent, the form below grants Xavier University of Louisiana representative's permission to care for you. The nearest relative or contact person will be notified as soon as possible.

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.

Student Name (print) _____ DOB ____/____/____
Last First Middle

Student Signature _____ Date ____/____/____

Parent/Guardian's Name (print) _____ Date ____/____/____
Last First Middle

Personal Physician (print) _____ Phone () _____

EMERGENCY CONTACT PERSON ENFORMATION

Name: _____ Relationship _____

Address _____

Phone: Home () _____ Work () _____

Cellular () _____ Email _____