



XAVIER UNIVERSITY OF LOUISIANA
STUDENT HEALTH ASSESSMENT FORM

Type or print in blue or black ink only

Program _____ Fall _____ Spring _____ Summer _____ 20 _____

Student ID# _____ (or SSN #)

Name: _____
LAST FIRST MIDDLE

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

Classification: Fresh ____ Soph ____ Junior ____ Senior ____ Transfer ____ Transient ____

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

Home Address _____
P.O. BOX / STREET CITY STATE ZIPCODE

Home Phone:() _____ Cellular Phone:() _____

Address while attending Xavier: _____
(List Name of Dormitory if known) PO BOX / STREET CITY STATE ZIPCODE

Student Contact Phone # while attending Xavier :(____) _____

Xavier University Medical Insurance Coverage Policy:

All undergraduate students are required to have medical insurance coverage. If you have insurance that will cover you in the New Orleans area 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 website for waiver → www.gallagherkoster.com

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 have had:

Alcoholism _____	Gallbladder Disease _____
Arthritis _____	Gastric reflux _____
Anorexia Nervosa _____	Hay fever _____
Asthma _____	Hearing disorder (right/left) _____
Back pain _____	Heart disease _____
Bipolar Disorder _____	Hepatitis _____
Bladder infection _____	High blood pressure _____
Blindness _____	Kidney problem _____
Bronchitis _____	Low back pain _____
Bulimia _____	Meningitis _____
Cerebral palsy _____	Mitral valve prolapse _____
Chronic pain (Specify) _____	Multiple sclerosis _____
Colitis _____	Obesity _____
Deafness _____	Paralysis _____
Depression _____	Peptic ulcer _____
Diabetes _____	Pneumonia _____
Drug/substance abuse _____	Pregnancy (how many months) _____
Dysmenorrhea _____	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

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 so how many cigarettes per day? _____ or Packs per day _____

List any surgeries: _____

Student's Signature: _____ Date: ____/____/____

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

REQUIRED IMMUNIZATION FORM

**THIS PAGE MUST BE COMPLETED AND SIGNED BY YOUR PHYSICIAN.
WE WILL NOT ACCEPT ANY ATTACHMENTS EXCEPT WHERE INDICATED.**

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

T.B. 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 applied ____/____/____ Site of injection _____ Lot # _____ Manufacturer _____

Date read ____/____/____ Results (mm) _____ (Copy of Chest X-ray report 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 or Official Stamp _____

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

Date ____/____/____ Lot# _____ Manufacturer _____

Health Care Provider's Signature or 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

Health Care Provider's Signature or Official Stamp _____ Date ____/____/____

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

Health Care Provider's Signature or Official Stamp _____ Date ____/____/____

SUGGESTED IMMUNIZATIONS, NOT REQUIRED, INDICATE DOCUMENTATION:

HEPATITIS B: Three Doses Required

VARICELLA: Two Doses Required

Dates: #1 _____

#1 _____

#2 _____

#2 _____

#3 _____

OR

Enclose copy of Serologic Results

Health Care Provider's Signature or Official Stamp _____ Date ____/____/____



**XAVIER UNIVERSITY OF LOUISIANA
HEALTH SERVICE HEALTH ASSESSMENT 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's Name (Print) _____ DOB ____/____/____
Last First Middle

Student's Signature _____ Date ____/____/____

Parent/Guardian's Name (Print) _____
(If student is a minor) Last First Middle

Parent/Guardian's Signature _____ Date ____/____/____
(If student is a minor)

Personal Physician (Print) _____ Phone # () _____

Emergency Contact Person Information

Name: _____ Relationship _____

Address: _____

Phone: Home () _____ Phone: Work () _____

Name: _____ Relationship _____

Address: _____

Phone: Home () _____ Phone: Work () _____
