



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 \_\_\_\_\_ Other \_\_\_\_\_ (Specify) \_\_\_\_\_

Student ID# \_\_\_\_\_ (or SSN #)

Name: \_\_\_\_\_  
*LAST FIRST MIDDLE*

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Home Address \_\_\_\_\_  
*P.O. BOX / STREET CITY STATE ZIPCODE*

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

E-mail Address: \_\_\_\_\_

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 are covered by insurance, you may decline to be enrolled in the schools 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 have 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 Disorders _____	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

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

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-rays required if TB test is Positive)  
**HISTORY OF POSITIVE TB SKIN TEST: Complete TB interview or have M.D. send a statement documenting the date of positive skin test and present health status.**

**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)**

**Enclose Copy of Titer Results: Rubeola / Mumps / Rubella (if no records of immunization available)**

MMR #1 DOSE \_\_\_\_/\_\_\_\_/\_\_\_\_ MMR #2 DOSE \_\_\_\_/\_\_\_\_/\_\_\_\_

**OR**

MEASLES (RUBEOLA)

1<sup>ST</sup> Dose \_\_\_\_/\_\_\_\_/\_\_\_\_ MUMPS Dose \_\_\_\_/\_\_\_\_/\_\_\_\_ RUBELLA Dose \_\_\_\_/\_\_\_\_/\_\_\_\_

2<sup>nd</sup> Dose \_\_\_\_/\_\_\_\_/\_\_\_\_

**Health Care Provider's Signature/ Official Stamp** \_\_\_\_\_

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

**Health Care Provider's Signature/ Official Stamp** \_\_\_\_\_

## Other Suggested Immunizations

HEPATITIS B: Three Doses Required

Dates: #1 \_\_\_\_\_

#2 \_\_\_\_\_

#3 \_\_\_\_\_

VARICELLA: Two Doses Required

#1 \_\_\_\_\_

#2 \_\_\_\_\_

**OR**

Enclose copy of TITER Results

**Health Care Provider's Signature/ Official Stamp** \_\_\_\_\_

