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Returning students will be required to update those immunizations that are outdated.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:

<table>
<thead>
<tr>
<th>Physical Location</th>
<th>Mailing Address</th>
<th>Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Joseph Academic &amp; Health</td>
<td>Xavier University of LA</td>
<td>(504) 520-7962</td>
</tr>
<tr>
<td>Resource Center 2nd floor - 217</td>
<td>Student Health Services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 Drexel Drive - Box 36</td>
<td></td>
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<tr>
<td></td>
<td>New Orleans, LA 70125</td>
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</tbody>
</table>

**Required Immunizations**

**Measles, Mumps, Rubella (MMR) requirement:** Two (2) doses of live vaccine required at least 28 days apart, 1st 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.
Required Immunizations
(Louisiana R.S. 17:170 Schools of Higher Learning)

Student ID#__________________________ (or SSN #)  Fall  __Spring  __Summer  __ 20

Name: __________________________________________________________________________________________

Birth Date: __________ / __________ / __________  Age: __________  Sex: __________  On Campus  __Off Campus

Home Address: __________________________________________________________________________________________

Home Phone: (__________) ___________________  Cellular Phone: (__________) ___________________  E-mail: __________________________________________________________________________

Clinical 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 or volunteer in a prison, nursing home, homeless shelter or hospital?  □ 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

Provider Signature: __________________________________________________________________________ Date: __________/________/________

Address: __________________________________________________________________________ Phone#: (__________) ___________________
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:

______________________________________ ______________________     ______________________
(Print) Student/Participant Name                                        ID#                                    Date of Birth

I hereby authorize the Xavier University Health Services Center 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): __________________________________________________________

Parent/Guardian’s Signature: _______________________________________________   ______________

Home Phone: (        ) _______________________ Cellular Phone:  (        ) ___________________________

EMERGENCY CONTACT INFORMATION:

Name (Print): ___________________________________________________   _____________________

Home Phone: (        ) _________________________ Cellular Phone:  (        ) _________________________

Name (Print): ___________________________________________________   _______________________

Home Phone: (        ) _________________________ Cellular Phone:  (        ) _________________________