XAVIER
UNIVERSITY OF LOUISIANA

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Returning students will be required to update those immunizations that are outdated.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, faxed or Uploaded:

Office Location / Fax Number	Mailing Address	Secure Upload
St. Joseph Academic & Health Resource Center 2nd floor - 217 Office: (504)520-7396 **Fax: (504)520-7962**	Xavier University of LA Student Health Services 1 Drexel Drive - Box 36 New Orleans, LA 70125	Students may sign in to their My XULA account and then log into PyraMED Student Portal.

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.

COVID-19 Vaccine: Two (2) doses of the Moderna vaccine required at least 28 days apart or Two (2) doses of Pfizer vaccine at least 21 days apart or One (1) dose of Johnson & Johnson Janssen vaccine. Second doses administered within a grace period of 4 days earlier than recommended date is valid and second doses administered up to 6 weeks after the first dose is valid. Please identify the vaccine taken by circling Moderna or Pfizer on the form or you may attach a copy of your vaccine card.

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.

XAVIER
UNIVERSITY OF LOUISIANA

Required Immunizations
(Louisiana State Legislature R.S.17:170)
Schools of Higher Learning

STUDENT COMPLETES

Student ID# _____ (or SSN #) Fall ☐ Spring ☐ Summer ☐ 20 ☐

Name: _____
LAST FIRST MIDDLE

Birth Date: ☐/☐/☐ Age: ☐ Sex: ☐ ☐ On Campus ☐ Off Campus

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

Home Phone : (☐) _____ Cellular Phone: (☐) _____ E-mail: _____

MUST BE COMPLETED, SIGNED & STAMPED BY HEALTHCARE PROVIDER

Two (2) doses of MMR required at least 28 days apart. 1st dose after 12 months of age. If born prior to 1957 vaccine not required.

MMR#1 _____ DATE **MMR#2** _____ DATE

OR

MEASLES (RUBEOLA) #1 _____ DATE **#2** _____ DATE

MUMPS _____ DATE **RUBELLA** _____ DATE

OR COPY OF SEROLOGIC TEST (Titers)

COVID-19 VACCINE

Two (2) doses of Moderna or Pfizer required at least 21- 28 days apart depending on the vaccine or One (1) dose of Johnson & Johnson.

Moderna / Pfizer #1 _____ **#2** _____

J & J _____

TD, T-dap
Dose must be within last 10 years. (T-dap recommended)

_____ DATE

MENINGITIS
(Quadrivalent vaccine A, C, Y, W-135) One (1) dose required at 16yrs. of age or older. 55yrs. or older vaccine not required.

_____ DATE

RECOMMENDED IMMUNIZATION(S)

VARICELLA (2 DOSES)

VARICELLA#1 _____ DATE **VARICELLA#2** _____ DATE

HEPATITIS B (3 DOSES)

HEPATITIS#1 _____ DATE **HEPATITIS#2** _____ DATE

HEPATITIS#3 _____ DATE

Provider Signature: _____ Date: ☐/☐/☐

Address: _____ Phone#: (☐) _____

CLINIC 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 / volunteer in a prison, nursing home, homeless shelter or hospital in the last six months?	☐ Yes	☐ No
4. Do you take immunosuppressive medications that suppress the immune system?	☐ Yes	☐ No
5. Do you have a suppressed immune system due to: (Chemotherapy, HIV, AIDS)?	☐ 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#: (☐) _____

CLINIC STAMP

CONSENT FOR CARE
FOR ALL STUDENTS 17YRS. OR YOUNGER PARTICPATING 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**

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: (___) _____

Name (Print): _____ _____
Last First MI Relationship

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

Office of Student Health Services, 1 Drexel Dr., Box 36, New Orleans, LA 70125 (504)520-7396